COLUMBIAN LIFE INSURANCE COMPANY • HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE
P.O. BOX 4850 • NORCROSS, GA 30091-4850
Phone (800) 305-1335
www.cfglife.com

FAX TO: (877) 261-3266*

APPLICATION FAX COVER SHEET CHECKLIST
Total Number of Pages:

NAME OF PROPOSED INSURED: John D Doe

Before faxing an application, complete the following checklist to ensure prompt processing and service. Please use a separate cover sheet for each application.

Fax the following:
- ☒ Properly signed and completed application
- ☐ If applying for the Children's Term Insurance Rider, include the rider application
- ☒ Any additional forms required (replacement, disclosures, etc.)

If submitting first premium with the application:
- ☐ Check for initial premium, made payable to Columbian Life Insurance Company and signed by the account holder (no money orders, cashier's checks or agency checks)
- ☐ Signed Authorization to Fax Check, Form No. 5079CFG-U

If first premium will be drafted:
- ☒ Voided check or deposit slip from the account to be drafted (checking or savings)

Do not reduce when copying applications. Form number on each form must be legible.

Agent Name: Cody M. Beck

Agent E-Mail Address: Cbeck@equisfinancial.com

Agent Phone No.: (937) 307-2089

***Use this fax number and cover sheet only for Columbian Life applications. If faxing an application for Columbian Mutual Life (New York only), use Application Fax Cover Sheet No. 2382-U and dial the fax number indicated on that form.**

APPLICATION FOR INDIVIDUAL WHOLE LIFE INSURANCE POLICY

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: PO Box 1381, Binghamton, NY 13902-1381

MAIL POLICY TO: ☒ Owner ☐ Agent **Reference ID:** Aptical - 111111

1. PROPOSED INSURED

First Name	Middle Initial	Last Name	Social Security No./Green Card No.
John	D	Doe	222-22-2222

Sex	Age (Last Birthday)	Date of Birth (MM/DD/YYYY)	State (USA) / Country of Birth	Home Phone: 937-832-1378 Cell Phone:
☒ M ☐ F	55	11-22-1960	OH USA	Email: Johndoe@gmail.com

Home Address/Apt. #, Street	City	State	Zip Code
895 Herr St	Englewood	OH	45322

Answer only for ages 25-35: Do you have a Driver's License? ☒ YES ☐ NO
If YES, please provide your Driver's License No. and State.
If NO, please provide details in Section 6 Special Requests / Remarks on Page 3.

Driver's License No.	State
RW111 111	OH

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

First Name	Middle Initial	Last Name	Relationship to Proposed Insured

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

Date of Birth (MM/DD/YYYY)	Social Security No./Green Card No.	Home Phone:	Cell Phone:
		Email:	

To designate a Contingent Owner, provide information in Section 6 Special Requests / Remarks on Page 3.

3. BENEFICIARY For multiple Primary or Contingent Beneficiaries, provide additional beneficiary information including % share in Section 6 Special Requests/ Remarks on Page 3.

PRIMARY BENEFICIARY First Name	Middle Initial	Last Name	Relationship to Proposed Insured
Mary	A	Doe	Wife

Date of Birth (MM/DD/YYYY)	Social Security No./Green Card No.	Home Phone: 937 832-1378	Cell Phone:
12-25-1960	333-33-3333	Email:	

Mailing Address/Apt. #, Street	City	State	Zip Code
895 Herr St Englewood OH 45322	Englewood	OH	45322

CONTINGENT BENEFICIARY First Name	Middle Initial	Last Name	Relationship to Proposed Insured

Date of Birth (MM/DD/YYYY)	Social Security No./Green Card No.	Home Phone:	Cell Phone:
		Email:	

Mailing Address/Apt. #, Street	City	State	Zip Code

4. POLICY INFORMATION ☐ Check here if you are willing to accept any plan shown below, for which you qualify based on this application. The insurance for which you qualify may have a return of premium death benefit for the first two (2) or three (3) years, a face amount less than indicated on this application and riders may not be available. Adjust the face amount to match premium? ☐ Yes ☐ No

Requested Effective Date / Draft Date
11 / 1 / 2016

Base Plan of Insurance
- ☒ Full Benefit Whole Life - Dignified Choice **Classic Elite**
- ☐ Full Benefit Whole Life - Dignified Choice **Classic Select**
- ☐ Graded Benefit Whole Life – Dignified Choice **Classic Advantage**
- ☐ Graded Benefit Whole Life – Dignified Choice **Classic Security**

TOBACCO USE
Have you used any form of tobacco or nicotine products, including cigarettes, cigars, pipes, e-cigarettes, chewing tobacco, snuff, nicotine patches or nicotine gum, within the last 12 months? ☐ YES ☒ NO

Amount Paid / Received with Application (Indicate $0 if initial premium is to be drafted.)	Amount of Insurance (Face Amount)	Amount of Base Modal Premium (Minus Riders)	Riders (If available)	Rider Premium	Automatic Premium Loan (**MUST select Yes or No**)
$ 0	$ 35,000	$ 121.16	☐ Accidental Death Benefit ☐ Children's Term Insurance Rider ☐ Accelerated Benefit Rider – Terminal Illness	$_____ $_____ (No Charge)	☒ Yes ☐ No

Payment Frequency ☒ Monthly ☐ Quarterly ☐ Semi-Annual ☐ Annual

Payment Method ☒ Draft 1st Premium* ☒ Automated Electronic Funds Transfer * ☐ Direct Bill (Annual, Semi-Annual or Quarterly only)
*If selecting Draft 1st Premium or EFT, please complete authorization on Page 4. ☐ List Bill / Group Bill (if available)

5. HEALTH HISTORY

Any person who knowingly presents a false statement in an application for life insurance may be guilty of a criminal offense and subject to penalties under state law.

What is your current height and weight? HEIGHT 5 Ft. 10 In. | WEIGHT 222 lbs.

PART 1 (If any question in this section is answered "YES," DO NOT SUBMIT THE APPLICATION)	YES	NO
1. Are you currently hospitalized, confined to a nursing home, hospice, bed, assisted living facility, convalescent home, institutionalized, receiving home health care, or confined to a wheelchair due to illness or disease?	☐	☒
2. Have you ever been diagnosed by a member of the medical profession as having or tested positive for Human Immunodeficiency Virus (HIV), or having an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or have you been diagnosed by a member of the medical profession as having a terminal medical condition that is expected to result in death within the next twelve (12) months?	☐	☒
3. Have you ever been recommended by a member of the medical profession, 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?	☐	☒
4. Are you awaiting a diagnosis or test result, or been advised by a member of the medical profession to have a surgical operation, a diagnostic test (except for HIV) other than for routine screening, that has not been completed?	☐	☒
PART 2 (If any question in this section is answered "YES," the Proposed Insured will be considered for the Classic Security Graded Benefit plan.)	YES	NO
1. Have you ever been diagnosed by a member of the medical profession with, or received treatment for: mental retardation, Down's Syndrome, cerebral palsy, muscular dystrophy, spina bifida, cystic fibrosis, sickle cell anemia, or Huntington's Disease?	☐	☒
2. Have you ever been diagnosed or treated (including taking medication) by a member of the medical profession with congestive heart failure, Alzheimer's disease, dementia or Lou Gehrig's disease (ALS), or received a cardiac defibrillator implant (except pacemaker implant)?	☐	☒
3. During the last twenty-four (24) months, have you been diagnosed or treated (including taking medication) by a member of the medical profession for any form of cancer, including, leukemia, melanoma or any other internal cancer (other than basal cell skin cancer)?	☐	☒
4. During the last six (6) months have you been diagnosed by a member of the medical profession as having a heart attack?	☐	☒
PART 3 (If any question in this section is answered "YES," the Proposed Insured will be considered for the Classic Advantage Graded Benefit plan. If two or more questions are answered "YES," the Proposed Insured will be considered for the Classic Security Graded Benefit plan.)	YES	NO
1. Have you ever been diagnosed, treated, (including taking medication), tested positive for, or been advised by a member of the medical profession to seek treatment for chronic lung disease, chronic obstructive pulmonary disease (COPD), chronic bronchitis, emphysema, black lung disease, chronic respiratory disorder (excluding asthma or sleep apnea), or used oxygen to assist with breathing (except for sleep apnea)?	☐	☒
2. During the last thirty-six (36) months, have you been diagnosed or received treatment (including taking medication) by a member of the medical profession for:		
a. Kidney disease, kidney failure, liver disease, chronic hepatitis, drug or alcohol abuse or dependency, sarcoidosis or Systemic Lupus?	☐	☒
b. Multiple Sclerosis, Parkinson's Disease, schizophrenia, brain tumor or have you been hospitalized or institutionalized for a mental or nervous disorder?	☐	☒
3. In the past thirty-six (36) months, have you:		
a. Been on probation, parole, been convicted of, or pled guilty to any crime or to possession or distribution of drugs or any other illegal substance?	☐	☒
b. Been convicted of three (3) or more moving violations, or been convicted of driving under the influence of alcohol or drugs?	☐	☒
4. During the last twenty-four (24) months, have you been diagnosed by a member of the medical profession as having: A stroke (including TIA), aneurysm, enlarged heart, angina, peripheral vascular disease, pacemaker implant, stent, angioplasty, bypass surgery, or any procedure to improve the circulation to the brain?	☐	☒
5. During the last thirty-six (36) months, have you been diagnosed by a member of the medical profession as having complications of diabetes, including insulin shock, diabetic coma, Retinopathy (eye), Nephropathy (kidney), Neuropathy (nerve, circulatory), Peripheral Artery Disease (PAD) or Peripheral Vascular Disease (PVD), or diabetes not under control with current treatment, or have you used insulin for the treatment of diabetes prior to age 50?	☐	☒
6. During the last seven to twenty-four (7–24) months have you been diagnosed by a member of the medical profession as having a heart attack?	☐	☒
PART 4 (If any question in this section is answered "YES," the Proposed Insured will be considered for the Classic Select Full Benefit Plan. If two or more questions are answered "YES," the Proposed Insured will be considered for the Classic Advantage Graded Benefit plan.) If all questions in all sections are answered "NO," the Proposed Insured will be considered for the Classic Elite Full Benefit plan.	YES	NO
1. In the past five (5) years, have you been diagnosed, treated, (including taking medication), tested positive for, or been advised by a member of the medical profession to seek treatment for cancer, leukemia, melanoma or any other internal cancer (except basal cell carcinoma)?	☐	☒
2. Have you ever been diagnosed, treated, (including taking medication), tested positive for, or been advised by a member of the medical profession to seek treatment for chronic asthma or atrial fibrillation?	☐	☒
3. Are you currently requiring the assistance of another person in performing any ADL's (Activities of Daily Living) including eating, bathing, dressing, toileting, continence, transferring in and out of a bed or chair, or taking medications?	☐	☒

PART 5 Please provide the following details for your most recent consultation with a physician or medical facility.

Date of last visit	Name & Address of Physician or Medical Facility	Reason Consulted	Treatment / Diagnosis

6. SPECIAL REQUESTS / REMARKS / CONTINGENT OWNER DESIGNATION / ADDITIONAL BENEFICIARY INFORMATION

7. REPLACEMENT

	YES	NO
Does any Proposed Insured have any existing life insurance or annuities?	☒	☐
Is this application for insurance intended to replace any life insurance or annuities now in force?	☐	☒

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

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. No information about the Proposed Insured will be considered to have been given to the Company unless it is stated in this application. 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 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, MIB, Inc., consumer reporting agency, or other organization, institution or person that has any records or knowledge of me, or any person proposed for insurance, 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 authorize** Columbian Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. **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, or the time limit permitted by applicable law in the state where the policy is delivered or issued for delivery. 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 understand the fraud warning in Section 5 of this application.**

10-20-2016	X John D Doe	10-20-2016	
Date of Application	Signature of Proposed Insured (Parent/Guardian if 15 or under)	(Date)	
Englewood OH	X		
Signed At (City, State)	Signature of Owner (If other than Insured)	(Date)	

10. REPORT OF LICENSED AGENT

Does any Proposed Insured have any existing life insurance or annuities?	☒ YES	☐ NO
Is this insurance intended to replace, in whole or part, any life insurance or annuities?	☐ YES	☒ NO

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

HAS THE TELEPHONE INTERVIEW BEEN COMPLETED? ☒ YES ☐ NO

Cody M. Beck	555555	100%
Primary Agent Name	Agent Number	Agent % Split
Secondary Agent Name	Agent Number	Agent % Split

I hereby affirm that I personally solicited, and completed this application and all answers given above are true and correct to the best of my knowledge. The application was signed in my presence.

Cody M. Beck	X Cody M. Beck	10-20-2016
Name of Licensed Agent (Print)	Signature of Licensed Agent *(required)*	(Date)

SECONDARY ADDRESSEE / THIRD PARTY DESIGNEE

(The Applicant/Owner may designate a Secondary Addressee/Third Party to receive a copy of notifications of a past due premium and possible lapse in coverage.)

☒ Not Designating A Secondary Addressee/Third Party At this Time; or

☐ Designating a Secondary Addressee / Third Party (include full name and address of the designee):

_____

PAYOR (Complete only if the Payor is not the Owner.)

First Name	Middle Initial	Last Name or Company Name if the Payor is a Corporation		
Mailing Address (Apt. #, Street)		City	State	Zip Code
Home Phone: Cell Phone:		Email:		

INITIAL PREMIUM PAYMENT

Amount of Initial Premium: $ 121.16

☒ Draft initial premium from the account below at a future date. **If you select an initial premium draft date in the future, you will not have potential coverage until that date under the Conditional Receipt.**
- When specifying a day of the month (the 1st through the 28th), the first draft must be within 30 days of the application date.
- When specifying a day of the week and week of the month (e.g., the third Wednesday of the month), the first draft must be within 35 days of the application date.

☐ Draft initial premium **upon receipt** of the application at Columbian's office, from the account below. **Please note that your bank account may be debited the same day your agent submits this application.**

☐ Check, cashier's check or money order. By signing below, you authorize the Company to initiate an electronic funds transfer from your bank account if payment is made by check. **Please note that your bank account may be debited the same day your agent submits this authorization.**

ONGOING PREMIUM PAYMENTS

☐ Direct Bill (not available for monthly payment mode)

☒ Electronic Funds Transfer

I request withdrawal of payments on: (CHOOSE ONE) Date (1st through 28th) 1 (OR) Week (1st - 4th) _____ / Day (Mon - Fri) _____

beginning in the month of November .

BANK ACCOUNT AUTHORIZATION (Complete if initial premium or ongoing premiums will be drafted from an account.)

I authorize the payment of debits drawn on my account payable to Columbian Life Insurance Company, provided there are sufficient funds in the account. I agree that if any such debit be dishonored, you shall be under no liability in the event the dishonored debit results in forfeiture of insurance.

Any requirement for giving notice of premiums due shall be waived as long as this Electronic Funds Transfer plan is in effect. No premium shall be deemed to have been paid until the Company receives actual payment. The use of this plan shall in no way change the provisions of the policy with respect to the termination of such policy upon nonpayment of the premium due.

This plan shall continue in effect until terminated by the Company or by me by thirty days written notice to the other party. The Company may terminate the EFT plan if any check or electronic fund transfer is not paid on presentation. Upon termination of the Electronic Funds Transfer plan, premiums due under the policy after such termination shall be payable directly to the Company at the minimum modal premium available at the time of issue.

Financial Institution Wright Patt Credit Union Account Type: ☒ Checking **(attach voided check if available)** or ☐ Savings

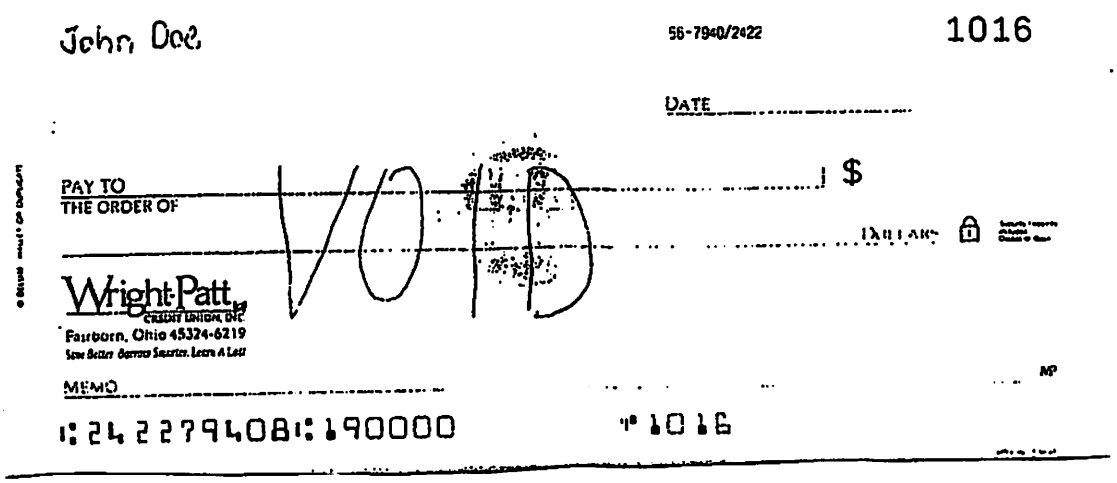
Transit / Routing Number 2 4 2 2 7 9 4 0 8 Must have 9 digits in routing number.

Account Number 1 9 0 0 0 0 May have up to 17 positions in account number.

John D Doe
Name of Bank Account Holder

10-20-2016
Date

X John D Doe
Authorized Signature as it appears on Bank Records


John Doe

56-7940/2422

1016

DATE

PAY TO
THE ORDER OF

VOID

$

DOLLARS

Wright-Patt
CREDIT UNION, INC.
Fairborn, Ohio 45324-6219
Save Better. Borrow Smarter. Learn A Lot!

MEMO

MP

⑆242279408⑆190000 ⑈1016

COLUMBIAN LIFE INSURANCE COMPANY • HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICES:
PO BOX 1381 • BINGHAMTON, NY 13902-1381
PO BOX 1056 • SYRACUSE, NY 13201-1056
PO BOX 4850 • NORCROSS, GA 30091-4850

Important Disclosures
Accelerated Benefit Rider

This briefly describes the provisions of the Accelerated Benefit Rider. Consult your rider for specific information. Please read your policy and rider carefully.

The Accelerated Benefit Rider allows you to elect to receive an advance on the death benefit of the policy when the Insured is diagnosed as having a non-correctable terminal illness which, in the best medical judgment of a physician, will result in the death of the insured within twelve (12) months from the date of the diagnosis. Diagnosis must be made during the time the rider and the policy are in force.

The Accelerated Benefit is equal to fifty percent (50%) of the insured's base policy death benefit. We will pay this amount less any loan (and unpaid loan interest) on the policy, any due and unpaid premium, and an Administrative Service Fee of $250.00. The policy loan and unpaid loan interest will be repaid. There will be no change in premiums. Regular premium payments as specified in the policy will be required in order to keep the policy in force. We will establish a lien against the death benefit of the policy equal to the amount of the Accelerated Benefit, plus accrued interest at the Accelerated Benefit interest rates. At the death of the insured, we will deduct the lien from the death benefit of the policy. If the Policy has a Surrender Value, the total amount of the lien and any policy loans and loan or lien interest will be deducted from the Surrender Value of the policy. If the total of all liens, loans and loan interest equals or exceeds the death benefit of the Policy, the Policy will terminate.

IF AN ACCELERATED BENEFIT IS PAID THE POLICY DEATH BENEFIT AND SURRENDER VALUE WILL BE REDUCED. RECEIPT OF ACCELERATED BENEFITS MAY BE TAXABLE. YOU SHOULD CONSULT YOUR PERSONAL TAX ADVISOR TO DETERMINE THE CURRENT TAX CONSEQUENCES PRIOR TO MAKING ANY ELECTION.

The rider may affect your ability to receive certain government benefits or entitlements. The Accelerated Benefit may be considered an asset in determining eligibility. You should contact your local Medicaid Unit and the Social Security Administration for more information.

The Accelerated Benefit Rider is not long-term care insurance and does not provide long-term care benefits.

There is no premium charge for the rider; however, there is a $250 Administrative Service Fee for processing an Accelerated Benefit payment.

I hereby acknowledge that I have received a copy of this statement. I understand that there is no premium charge for the rider, but there will be a $250 Administrative Service Fee for processing an Accelerated Benefit payment. I understand that the rider may affect my ability to receive certain government benefits or entitlements and that receipt of an Accelerated Benefit may be taxable.

John D Doe	10-20-2016
Signature of Applicant/Owner	Date
John D Doe	222-22-2222
Printed Name of Applicant/Owner	Social Security Number
Cindy M. Beck 8888888	10-20-2016
Signature of Licensed Agent License No.	Date

IMPORTANT NOTICE: REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

COLUMBIAN MUTUAL LIFE INSURANCE COMPANY • HOME OFFICE: BINGHAMTON, NY
COLUMBIAN LIFE INSURANCE COMPANY • HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICES:
VESTAL PARKWAY EAST • PO BOX 1381 • BINGHAMTON, NY 13902-1381
507 PLUM STREET • PO BOX 1056 • SYRACUSE, NY 13201-1056
655 ENGINEERING DRIVE • 3RD FLOOR • PO BOX 4850 • NORCROSS, GA 30091-4850

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interests. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES _X_ NO
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES _X_ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an in force illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because No Replacement

I certify that the responses herein are, to the best of my knowledge, accurate:

John D Doe John O Doe — 10-20-2016
Applicant's Signature and Printed Name — Date

Cody M. Beck Cody M. Beck — 10-20-2016
Producer's Signature and Printed Name — Date

I do not want this notice read aloud to me. JD *(Applicants must initial only if they do not want the notice read aloud.)*

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
- Are they affordable?
- Could they change?
- You're older -- are premiums higher for the proposed new policy?
- How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
- New policies usually take longer to build cash values and to pay dividends.
- Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
- What surrender charges do the policies have?
- What expense and sales charges will you pay on the new policy?
- Does the new policy provide more insurance coverage?

INSURABILITY:
- If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
- You may need a medical exam for a new policy.
- Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
- Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:
- How are premiums for both policies being paid?
- How will the premiums on your existing policy be affected?
- Will a loan be deducted from death benefits?
- What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:
- Will you pay surrender charges on your old contract?
- What are the interest rate guarantees for the new contract?
- Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:
- What are the tax consequences of buying the new policy?
- Is this a tax free exchange? (See your tax advisor.)
- Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
- Will the existing insurer be willing to modify the old policy?
- How does the quality and financial stability of the new company compare with your existing company?

If a replacement is involved in the purchase of the new policy or contract, you may return it within thirty (30) days of receipt for a full refund of all premiums or considerations paid on it, including any policy fees or charges. For a variable or market value adjustment policy or contract, the amount paid will be the cash surrender value provided under the policy or contract plus the fees and other charges deducted from the gross premiums or considerations or imposed under the policy or contract. If the policy or contract is returned, the coverage will be considered void from the beginning.