COLUMBIAN MUTUAL LIFE INSURANCE COMPANY
HOME OFFICE: BINGHAMTON, NY
ADMINISTRATIVE SERVICE OFFICE: 507 PLUM STREET
PO BOX 1056, SYRACUSE, NY 13201-1056
TELEPHONE: (800) 347-0960 / www.ftlife.com

APPLICATION FOR
New Century Permanent Protection

Including the following forms:

- **Application for Electronic Funds Transfer (EFT)** Plan of Premium Payment – Form No. 5249CFG

Instructions to Agents

- The "Important Notice" must be given to the Applicant at time of application.
- **Insurance age** is calculated based on the Proposed Insured's **age nearest birthday.**
- The "Conditional Receipt" must be completed and given to the Applicant in all cases when a payment is submitted with the application. If no payment is received, enter "None" and submit the Conditional Receipt with the application. No agent has the authority to alter the provisions of the Conditional Receipt.
- Simplified Issue Life Insurance Coverage is available in any amount between $5,000 and $25,000. Use the check box in SECTION C.1. of the application or write the amount in the space. If you need additional space, use the Remarks SECTION E.
- The Accidental Death Benefit Rider is available for issue ages 0 – 65 in any amount between $5,000 and $25,000. Use the check box in SECTION C.1. of the application or write the amount in the space. If you need additional space, use the Remarks SECTION E. The ADB Rider amount applied for does not need to equal the amount of base coverage applied for.
- No other benefits or riders are available.
- Monthly bank draft (EFT), monthly list bill, and annual direct bill modes are available.
- Monthly premium rates and Height/Weight Table are included with this application kit.

IMPORTANT NOTICE

NOTICE OF INFORMATION PRACTICES /

COLLECTION OF INFORMATION

THIS NOTICE MUST BE GIVEN TO APPLICANT AT TIME OF APPLICATION

We must collect and evaluate enough information to establish your insurability. We do this so we can underwrite and administer your insurance coverage properly.

You are our most important source of information. We may also order an investigative consumer report about you. The investigating agency may call you. They might ask about your health. They might also ask you about your character, general reputation, personal characteristics, and mode of living.

Upon a written request, you will be informed whether or not an investigative consumer report was requested. If a report was requested, the name and address of the consumer reporting agency will be provided to you. You may receive and inspect a copy of the report by contacting the agency.

DISCLOSURES BY CML

We will not disclose your personal information to a third party without your separate approval, except as permitted by law.

ACCESS AND CORRECTION

There are procedures by which you can access your personal information that is in our policy files. This includes information in any investigative consumer report. You may request correction, amendment, or deletion of any of this information you believe is not correct or is not needed. We will send you these procedures and information contained in an investigative consumer report if you ask us for them. We have also established procedures by which you may request correction, amendment, or deletion of any information in our files, which you believe to be inaccurate or irrelevant. A description of these procedures will also be sent to you upon request.

OBTAINING ADDITIONAL INFORMATION

If you have any further questions about the items just discussed, please write us.

MEDICAL INFORMATION BUREAU (MIB)

Information regarding your insurability will be treated as confidential. CML, or its reinsurers may, however, make a brief report thereon to the Medical Information Bureau, a non-profit Membership organization of life insurance companies, which operates an information exchange on behalf of its Members. If you apply to another Bureau Member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the Bureau, upon request, will supply such company with the information in its file.

Upon receipt of a request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the Bureau's information office is Post Office Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (866) 692-6901, fax number (866) 346-3642.

Columbian Mutual Life Insurance Company, or its reinsurers, may also release information it its file to other life insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted.

OPT OUT

I realize I may opt out of this disclosure of non-public personal information to third parties. I may do so by placing a mark in the box that follows. CML will disclose other information as allowed by law. ❑ I Opt Out of disclosure of non-public personal information. I realize that CML can still disclose information as allowed by law. I agree this authorization is valid for 24 months from the date signed. I have received the "Important Notice". I know that if I ask for a copy of this authorization you must send one to me.

Dated at _____ on _____ 20___ _____

City and State — Signature of Proposed Insured

_____ _____

Witness Signature **if other than Soliciting Agent** — Signature of Proposed Owner or Trustee if other than Proposed Insured.

Keep this page for your records. It is not a contract. Should a policy be issued, the actual policy provisions will govern your benefits.

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Witness Signature **if other than Soliciting Agent** — Signature of Proposed Owner or Trustee if other than Proposed Insured.

Keep this page for your records. It is not a contract. Should a policy be issued, the actual policy provisions will govern your benefits.

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PO BOX 1056, SYRACUSE, NY 13201-1056
TELEPHONE: (800) 347-0960 / www.ftlife.com

New Century Permanent Protection
Application for Life Insurance

ANY POLICY ISSUED BASED ON THIS APPLICATION FOR INSURANCE IS ISSUED WITH LIMITED MEDICAL UNDERWRITING. THEREFORE, THE PREMIUM RATE BEING CHARGED INCLUDES AN EXTRA MORTALITY RISK CHARGE.

SECTION A	PERSON PROPOSED FOR INSURANCE Insurance Age is Age Nearest Birthday (Use Section E if additional space is needed)						
1. Proposed Insured	Name	Soc. Sec. No.	Sex	Birth Date	Birth Place	Height	Weight

2. Address	Number and Street	City	County	State	Zip

Insured's Home Phone No.: ( ) Best time to call: ❑AM ❑PM

3. Owner: If Owner is not the Proposed Insured

Name:	Relationship:	Soc. Sec. No.:
Address:		**If Contingent Owner enter in Section E**

SECTION B	NON-MEDICAL QUESTIONNAIRE (IF any "YES" RESPONSES, SIMPLIFIED ISSUE COVERAGE IS NOT AVAILABLE)	YES	NO
	1. Are you currently bedridden? Are you receiving home nursing care, hospitalized, or confined to a nursing facility? Have you ever been diagnosed as having a terminal illness or senile dementia?		
	2. Have you ever been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?		
	3. Have you ever had an application for life insurance declined by any company?		
	4. In the past five (5) years: Have you used or received treatment for illegal or controlled substances not prescribed by a physician? Have you received treatment of any kind for the use of alcohol?		
	5. Within the past ten (10) years: Have you been diagnosed as having, or received treatment for, any cancer other than a non-melanoma skin cancer?		
	6. Within the past three (3) years: Have you been treated or had surgery for a heart attack, congestive heart failure, or stroke? Have you been advised to have surgery for a heart condition or for any blood vessel disease but not had such surgery?		
	7. Within the past three (3) years: Have you had or been treated for grand mal seizure or cirrhosis of the liver? Have you had diabetes requiring treatment with insulin, kidney failure, or received dialysis?		
	8. Have you ever received or been advised to have an organ transplant, excluding a cornea transplant?		
	9. Have you ever been diagnosed or treated for Alzheimer's disease, paralysis with bowel or bladder impairment, major depression or schizophrenia, Parkinson's disease, Multiple Sclerosis, Cerebral Palsy, or Downs Syndrome? Have you ever been diagnosed or treated for Lupus or chronic lung disease including emphysema or chronic obstructive lung disease (COPD) using oxygen equipment to assist in breathing?		

SECTION C	COVERAGES APPLIED FOR / PREMIUM SCHEDULE / OTHER COVERAGE / REPLACEMENT?

1. Death Benefit: ❑$5,000 ❑$10,000 ❑$15,000 ❑$20,000 ❑$25,000
Accidental Death Benefit: ❑$5,000 ❑$10,000 ❑$15,000 ❑$20,000 ❑$25,000

2. Automatic Premium Loan ❑ **Yes** ❑ **No**

3. Dividend Option: ❑Cash ❑ Reduce Premium ❑ Accumulate at Interest ❑ Paid Up Additions. **If no option is selected, Paid Up Additions will be applied for.**

4. Tobacco Use:
Have you used tobacco in any form during the past 12 months? ❑ Yes ❑ No

5. Billing Frequency: ❑ Monthly (EFT or List Bill ONLY) ❑ Annual NO OTHER MODES ARE AVAILABLE
Check if: ❑ Government Allotment (Submit Gvt. Allot. Forms) ❑ List Bill (Complete billing information below)

6. List bill information: [Only if "List Bill" checked in C(5)]
List Sponsor (Employer, Association, etc.):
Estimated List Bill Date: List Number if Known:

7. Present Life Insurance/Annuity Contracts in Force. Include Company name and face amount. If none, check here. ❑

8. Do you intend to replace any existing life insurance policies or annuity contracts? ❑ Yes ❑ No
If the answer to question 7 or 8 is YES, please complete the required replacement notice.

SECTION D	BENEFICIARY				
Provide full name, percent of proceeds and relationship to Proposed Insured.					
Primary	%	Relationship	Contingent	%	Relationship

Unless otherwise noted in this or a later beneficiary designation, the right to change the beneficiary is reserved and the proceeds are to be divided equally among all persons who are named as Primary Beneficiary and who survive the insured. If none survive, then equally among all persons who are named as Contingent Beneficiary and who survive the insured.

SECTION E	REMARKS / ADDITIONAL INFORMATION (Use additional paper as necessary)

SECTION F	AGREEMENT / AUTHORIZATION TO OBTAIN AND DISCLOSE INFORMATION / ACKNOWLEDGEMENT

I have read the above statements. They are true and complete to the best of my knowledge and belief. I agree that this application will be attached to the policy if approved. The application will form a part of any policy issued. I understand that no agent may accept risk. I also understand that no agent can make or change the contract. The agent cannot waive any Columbian Mutual Life Insurance Company's (CML) rights or requirements. Applications will be approved or declined within 60 days. If not, I will be told why. The policy will not be effective unless I accept it. The first premium must be paid while I am still insurable.

I realize material misstatements on the application may result in a claim not being paid that otherwise would be. No misrepresentation shall be deemed material unless knowledge by CML of the facts misrepresented would have led to a refusal by CML to make the contract. I understand the policy shall be incontestable after being in force for a period of two years from its date of issue.

I hereby authorize any licensed physician, medical practitioner hospital, clinic or other medical or medically related facility, insurance company, the Medical Information Bureau (MIB), or other organization, institution or person, that has any records or knowledge of me or my health, to give to CML, or its reinsurers, any such information. That information (except the MIB Report) may also be given to CML's representatives. I authorize CML to get consumer reports on me. Information obtained from consumer reports will only be released by CML to the MIB, other insurance companies to which I have applied for coverage, or to others doing business or legal services in connection with my application. We will also release information as lawfully required. No information on HIV infection will be released. A photographic copy of this authorization shall be as valid as the original.

I agree that this authorization shall be valid for 24 months from the date signed. I acknowledge receipt of the Important Notice regarding investigative consumer reports, the Medical Information Bureau, and the Notice of Information Practices. A copy of this authorization is available upon request.

Dated at _____ on _____ 20___ _____

City and State — Signature of Proposed Insured

_____ _____

Witness Signature **if other than Soliciting Agent** — Signature of Proposed Owner or Trustee if other than Proposed Insured.

I hereby declare that this application was secured by me personally, or by another properly licensed agent. I further declare that the information supplied by the insured has been truly and accurately recorded on the application. I also declare that the Applicant, and Owner if other than Applicant, signed the application on the date indicated above. I recommend the proposed insured for insurance without reservation. I ❑ **am** ❑ **am not** aware of any existing life insurance or annuity contracts on the life of the proposed insured. If there are existing contracts, I presented and read to the applicant any required notice regarding replacement. I also declare that this policy ❑ **is** ❑ **is not** intended to replace, in whole, or in part, any policy or annuity contract in force in this or any other company. If a replacement is intended, the required forms and explanation are attached. The writing credit for this application shall be as indicated on the attached Writing Agent Interest Statement. Money submitted with application $_____ or ❑ None

_____

Soliciting Agent's Signature – **Required on all applications**

This page is not part of the application.

THIS PAGE MUST BE *COMPLETED AND RETURNED* WITH THE APPLICATION.

Writing Agent Interest Statement
Writing credit for this application shall be given to:

	Name	Code	%
Agency			
Agent			
Agency			
Agent			
Agency			
Agent			

Home Office Use Only

Policy No. Assigned:

Date Application Received:

Payment Received: $

MONTHLY PREMIUM RATES (Annual rates = Monthly / .086)
Annual / Monthly EFT / Monthly List Bill available – Direct Monthly not available.

MALE – Non-Tobacco							FEMALE – Non-Tobacco					
Age Nearest Birthday	$5,000	$10,000	$15,000	$20,000	$25,000		Age Nearest Birthday	$5,000	$10,000	$15,000	$20,000	$25,000
18-19	8.00	11.87	15.74	19.61	23.48		18-19	7.14	10.15	13.16	16.17	19.18
20-22	8.43	12.73	17.03	21.33	25.63		20-22	7.57	11.01	14.45	17.89	21.33
23-26	8.86	13.59	18.32	23.05	27.78		23-26	8.00	11.87	15.74	19.61	23.48
27-28	9.29	14.45	19.61	24.77	29.93		27-28	8.43	12.73	17.03	21.33	25.63
29-30	9.72	15.31	20.90	26.49	32.08		29-30	8.86	13.59	18.32	23.05	27.78
31-32	10.15	16.17	22.19	28.21	34.23		31-32	8.86	13.59	18.32	23.05	27.78
33-34	10.58	17.03	23.48	29.93	36.38		33-34	9.29	14.45	19.61	24.77	29.93
35-36	11.01	17.89	24.77	31.65	38.53		35-36	9.72	15.31	20.90	26.49	32.08
37-38	11.44	18.75	26.06	33.37	40.68		37-38	10.15	16.17	22.19	28.21	34.23
39	11.87	19.61	27.35	35.09	42.83		39	10.58	17.03	23.48	29.93	36.38
40	12.30	20.47	28.64	36.81	44.98		40	11.01	17.89	24.77	31.65	38.53
41	12.73	21.33	29.93	38.53	47.13	N	41	11.44	18.75	26.06	33.37	40.68
42	13.16	22.19	31.22	40.25	49.28	O	42	11.87	19.61	27.35	35.09	42.83
43	13.59	23.05	32.51	41.97	51.43	N	43	12.30	20.47	28.64	36.81	44.98
44	14.02	23.91	33.80	43.69	53.58	-	44	12.73	21.33	29.93	38.53	47.13
45	14.45	24.77	35.09	45.41	55.73	T	45	13.16	22.19	31.22	40.25	49.28
46	14.88	25.63	36.38	47.13	57.88	O	46	13.59	23.05	32.51	41.97	51.43
47	15.31	26.49	37.67	48.85	60.03	B	47	14.02	23.91	33.80	43.69	53.58
48	15.74	27.35	38.96	50.57	62.18	A	48	14.45	24.77	35.09	45.41	55.73
49	16.17	28.21	40.25	52.29	64.33	C	49	14.88	25.63	36.38	47.13	57.88
50	17.03	29.93	42.83	55.73	68.63	C	50	15.74	27.35	38.96	50.57	62.18
51	17.89	31.65	45.41	59.17	72.93	O	51	16.17	28.21	40.25	52.29	64.33
52	18.75	33.37	47.99	62.61	77.23		52	17.03	29.93	42.83	55.73	68.63
53	19.61	35.09	50.57	66.05	81.53	R	53	17.89	31.65	45.41	59.17	72.93
54	20.47	36.81	53.15	69.49	85.83	A	54	18.75	33.37	47.99	62.61	77.23
55	21.33	38.53	55.73	72.93	90.13	T	55	19.61	35.09	50.57	66.05	81.53
56	22.19	40.25	58.31	76.37	94.43	E	56	20.04	35.95	51.86	67.77	83.68
57	23.05	41.97	60.89	79.81	98.73	S	57	20.90	37.67	54.44	71.21	87.98
58	23.91	43.69	63.47	83.25	103.03		58	21.33	38.53	55.73	72.93	90.13
59	24.77	45.41	66.05	86.69	107.33		59	22.19	40.25	58.31	76.37	94.43
60	25.63	47.13	68.63	90.13	111.63		60	22.62	41.11	59.60	78.09	96.58
61	26.49	48.85	71.21	93.57	115.93		61	23.48	42.83	62.18	81.53	100.88
62	27.35	50.57	73.79	97.01	120.23		62	23.91	43.69	63.47	83.25	103.03
63	28.21	52.29	76.37	100.45	124.53		63	24.77	45.41	66.05	86.69	107.33
64	29.07	54.01	78.95	103.89	128.83		64	25.20	46.27	67.34	88.41	109.48
65	30.36	56.59	82.82	109.05	135.28		65	26.49	48.85	71.21	93.57	115.93
66	32.08	60.03	87.98	115.93	143.88		66	27.35	50.57	73.79	97.01	120.23
67	33.80	63.47	93.14	122.81	152.48		67	29.07	54.01	78.95	103.89	128.83
68	35.52	66.91	98.30	129.69	161.08		68	29.93	55.73	81.53	107.33	133.13
69	37.67	71.21	104.75	138.29	171.83		69	32.08	60.03	87.98	115.93	143.88
70	39.82	75.51	111.20	146.89	182.58		70	33.37	62.61	91.85	121.09	150.33
71	41.97	79.81	117.65	155.49	193.33		71	35.52	66.91	98.30	129.69	161.08
72	44.12	84.11	124.10	164.09	204.08		72	36.81	69.49	102.17	134.85	167.53
73	46.27	88.41	130.55	172.69	214.83		73	38.96	73.79	108.62	143.45	178.28
74	49.28	94.43	139.58	184.73	229.88		74	40.68	77.23	113.78	150.33	186.88
75	52.72	101.31	149.90	198.49	247.08		75	44.12	84.11	124.10	164.09	204.08
76	55.73	107.33	158.93	210.53	262.13		76	47.13	90.13	133.13	176.13	219.13
77	60.03	115.93	171.83	227.73	283.63		77	51.43	98.73	146.03	193.33	240.63
78	64.33	124.53	184.73	244.93	305.13		78	55.73	107.33	158.93	210.53	262.13
79	68.63	133.13	197.63	262.13	326.63		79	60.03	115.93	171.83	227.73	283.63
80	72.93	141.73	210.53	279.33	348.13		80	64.33	124.53	184.73	244.93	305.13

Accidental Death Benefit
Monthly Premium (Male Female)

Age	$5,000	10,000	15,000	20,000	25,000
18-65	$2.06	3.10	4.13	5.16	6.19

Height / Weight Table (Male/Female) – No Other Impairments

Height	Weight	Height	Weight	Height	Weight
4'8"	205	5'4"	240	6'0"	295
4'9"	210	5'5"	245	6'1"	305
4'10"	215	5'6"	250	6'2"	310
4'11"	218	5'7"	260	6'3"	320
5'0"	220	5'8"	265	6'4"	330
5'1"	225	5'9"	275	6'5"	335
5'2"	230	5'10"	280	6'6"	345
5'3"	235	5'11"	290	6'7"	350

MONTHLY PREMIUM RATES (Annual rates = Monthly / .086)
Annual / Monthly EFT / Monthly List Bill available – Direct Monthly not available.

MALE –TOBACCO							FEMALE – TOBACCO					
Age Nearest Birthday	$5,000	$10,000	$15,000	$20,000	$25,000		Age Nearest Birthday	$5,000	$10,000	$15,000	$20,000	$25,000
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23-26	9.72	15.31	20.90	26.49	32.08		23-26	8.86	13.59	18.32	23.05	27.78
27-28	10.15	16.17	22.19	28.21	34.23		27-28	9.29	14.45	19.61	24.77	29.93
29-30	10.58	17.03	23.48	29.93	36.38		29-30	9.72	15.31	20.90	26.49	32.08
31-32	11.44	18.75	26.06	33.37	40.68		31-32	10.15	16.17	22.19	28.21	34.23
33-34	11.87	19.61	27.35	35.09	42.83		33-34	10.58	17.03	23.48	29.93	36.38
35-36	12.30	20.47	28.64	36.81	44.98		35-36	11.01	17.89	24.77	31.65	38.53
37-38	13.16	22.19	31.22	40.25	49.28		37-38	11.44	18.75	26.06	33.37	40.68
39	13.59	23.05	32.51	41.97	51.43		39	11.87	19.61	27.35	35.09	42.83
40	14.02	23.91	33.80	43.69	53.58		40	12.30	20.47	28.64	36.81	44.98
41	14.88	25.63	36.38	47.13	57.88		41	12.73	21.33	29.93	38.53	47.13
42	15.31	26.49	37.67	48.85	60.03		42	13.16	22.19	31.22	40.25	49.28
43	15.74	27.35	38.96	50.57	62.18		43	13.59	23.05	32.51	41.97	51.43
44	16.17	28.21	40.25	52.29	64.33	T	44	14.02	23.91	33.80	43.69	53.58
45	16.60	29.07	41.54	54.01	66.48	O	45	14.45	24.77	35.09	45.41	55.73
46	17.46	30.79	44.12	57.45	70.78	B	46	14.88	25.63	36.38	47.13	57.88
47	17.89	31.65	45.41	59.17	72.93	A	47	15.31	26.49	37.67	48.85	60.03
48	18.32	32.51	46.70	60.89	75.08	C	48	15.74	27.35	38.96	50.57	62.18
49	18.75	33.37	47.99	62.61	77.23	C	49	16.17	28.21	40.25	52.29	64.33
50	19.61	35.09	50.57	66.05	81.53	O	50	17.03	29.93	42.83	55.73	68.63
51	20.90	37.67	54.44	71.21	87.98		51	17.89	31.65	45.41	59.17	72.93
52	21.76	39.39	57.02	74.65	92.28	R	52	18.75	33.37	47.99	62.61	77.23
53	22.62	41.11	59.60	78.09	96.58	A	53	19.61	35.09	50.57	66.05	81.53
54	23.48	42.83	62.18	81.53	100.88	T	54	20.47	36.81	53.15	69.49	85.83
55	24.34	44.55	64.76	84.97	105.18	E	55	21.33	38.53	55.73	72.93	90.13
56	25.63	47.13	68.63	90.13	111.63	S	56	22.19	40.25	58.31	76.37	94.43
57	26.49	48.85	71.21	93.57	115.93		57	23.05	41.97	60.89	79.81	98.73
58	27.78	51.43	75.08	98.73	122.38		58	23.91	43.69	63.47	83.25	103.03
59	28.64	53.15	77.66	102.17	126.68		59	24.77	45.41	66.05	86.69	107.33
60	30.36	56.59	82.82	109.05	135.28		60	25.63	47.13	68.63	90.13	111.63
61	31.22	58.31	85.40	112.49	139.58		61	26.49	48.85	71.21	93.57	115.93
62	32.94	61.75	90.56	119.37	148.18		62	27.35	50.57	73.79	97.01	120.23
63	33.80	63.47	93.14	122.81	152.48		63	28.21	52.29	76.37	100.45	124.53
64	35.52	66.91	98.30	129.69	161.08		64	29.07	54.01	78.95	103.89	128.83
65	36.81	69.49	102.17	134.85	167.53		65	30.36	56.59	82.82	109.05	135.28
66	39.39	74.65	109.91	145.17	180.43		66	32.08	60.03	87.98	115.93	143.88
67	41.11	78.09	115.07	152.05	189.03		67	33.80	63.47	93.14	122.81	152.48
68	43.69	83.25	122.81	162.37	201.93		68	35.52	66.91	98.30	129.69	161.08
69	45.84	87.55	129.26	170.97	212.68		69	37.67	71.21	104.75	138.29	171.83
70	48.85	93.57	138.29	183.01	227.73		70	39.82	75.51	111.20	146.89	182.58
71	51.00	97.87	144.74	191.61	238.48		71	41.97	79.81	117.65	155.49	193.33
72	54.01	103.89	153.77	203.65	253.53		72	44.12	84.11	124.10	164.09	204.08
73	56.16	108.19	160.22	212.25	264.28		73	46.27	88.41	130.55	172.69	214.83
74	60.03	115.93	171.83	227.73	283.63		74	49.28	94.43	139.58	184.73	229.88
75	63.47	122.81	182.15	241.49	300.83		75	52.72	101.31	149.90	198.49	247.08
76	66.48	128.83	191.18	253.53	315.88		76	55.73	107.33	158.93	210.53	262.13
77	70.78	137.43	204.08	270.73	337.38		77	60.03	115.93	171.83	227.73	283.63
78	75.08	146.03	216.98	287.93	358.88		78	64.33	124.53	184.73	244.93	305.13
79	79.38	154.63	229.88	305.13	380.38		79	68.63	133.13	197.63	262.13	326.63
80	83.68	163.23	242.78	322.33	401.88		80	72.93	141.73	210.53	279.33	348.13

Accidental Death Benefit
Monthly Premium (Male Female)

Age	$5,000	10,000	15,000	20,000	25,000
18-65	$2.06	3.10	4.13	5.16	6.19

Height / Weight Table (Male/Female) – No Other Impairments

Height	Weight	Height	Weight	Height	Weight
4’8”	205	5’4”	240	6’0”	295
4’9”	210	5’5”	245	6’1”	305
4’10”	215	5’6”	250	6’2”	310
4’11”	218	5’7”	260	6’3”	320
5’0”	220	5’8”	265	6’4”	330
5’1”	225	5’9”	275	6’5”	335
5’2”	230	5’10”	280	6’6”	345
5’3”	235	5’11”	290	6’7”	350

New Century Permanent Protection
Conditional Receipt

THIS CONDITIONAL RECEIPT DOES NOT CREATE TEMPORARY OR INTERIM INSURANCE. UNLESS EACH AND EVERY CONDITION IS MET, NO COVERAGE WILL TAKE EFFECT PRIOR TO THE ACTUAL RECEIPT OF THE POLICY. NO PERSON IS AUTHORIZED TO CHANGE OR WAIVE ANY OF THE FOLLOWING CONDITIONS (WHICH MAY APPLY TO EACH POLICY APPLIED FOR):

CONDITIONS

1. All responses to the Non-Medical Questionnaire (Section B of the Application for Life Insurance to which this Conditional Receipt is attached), must be "No", both in form and in fact; and
2. All payment must have been made with the application (any coverage effective shall be in force only for such fraction of one year as this payment bears to the annual premium); and
3. The proposed insured must be acceptable for coverage according to Columbian Mutual Life Insurance Company's (the Company) published underwriting rules in effect on the policy effective date.

EFFECTIVE DATE OF COVERAGE

"Effective Date" as used in this Conditional Receipt means the latest of:

1. the date of the application; or
2. the effective date requested in the application

COVERAGE LIMITATIONS

The amount of insurance payable as the result of this Conditional Receipt, including other pending applications with the Company, shall not exceed:

1. $25,000 for the Death Benefit applied for in Section C of the Application for Life Insurance to which this Conditional Receipt is attached
2. $25,000 of Accidental Death Benefit applied for in Section C of the Application for Life Insurance to which this Conditional Receipt is attached

AGREEMENT

If all conditions above are met, conditional insurance as provided by the terms and conditions of this receipt shall be in effect for the amount applied for, not to exceed the above coverage limits.

TERMINATION OF AGREEMENT

This agreement terminates on the earliest of the following dates:

1. on the date a policy is delivered to the applicant; or
2. on the 60th day after the date of this receipt; or
3. on the date the applicant receives notice that a policy cannot be issued. Unless receipt can be proven, a mailed notice will be deemed received five days after the mailing date.

If this Agreement terminates without issue of a policy, any payment received by the Company will be refunded.

Received from: _____, the sum of $ _____, for the life insurance coverage applied for. This receipt is not valid unless signed by a licensed agent of the Company; nor is it valid unless remittance if made by check or draft is honored on first presentation for payment.

Dated at _____ this _____ day of _____, _____
Month Year

_____
Signature of Agent