COLUMBIAN MUTUAL LIFE INSURANCE COMPANY
HOME OFFICE: BINGHAMTON, NY
ADMINISTRATIVE SERVICE OFFICE: 5788 WIDEWATERS PARKWAY
PO BOX 1056 • SYRACUSE, NY 13201-1056
TELEPHONE: (877) 238-5433 • www.ftlife.com

APPLICATION FOR
New Century
Senior Protector
Guaranteed Issue Whole Life

OHIO ONLY

INCLUDING THE FOLLOWING FORMS:

- **Application for Electronic Funds Transfer (EFT)** Form of Premium Payment – Form No. 17-091-00 EFT
- **Privacy Statement** – Form No. 4430CFG

Instructions to Agents

- **Insurance age** is calculated based on the Proposed Insured's **age nearest birthday.**
- The Privacy Statement must be given to the Applicant at time of application.
- The "Conditional Receipt" must be completed and given to the Applicant in all cases.
- **A minimum of one months' premium must be submitted with the application.**
- Minimum Annual, Semi-Annual and Quarterly premium is $25.00.
- Minimum monthly premium is $15.00.
- Mode premium factors are a fraction of Annual: Semi-Annual = .51; Quarterly = .265; Monthly = .10; EFT = .086
- Automatic Premium Loan (APL) must be answered "yes" or "no"
- A **Social Security or Tax ID Number must be provided** for the Insured and each Owner.
- Issue ages are 50 through 80.
- Coverage is available in amounts of $2,000 through $25,000.
- No other benefits or riders are available.
- Replacement question No. 6 must always be answered.

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APPLICATION FOR
NEW CENTURY SENIOR PROTECTOR - GUARANTEED ISSUE

FOR INSURANCE POLICIES ISSUED FOR SMALL FACE AMOUNTS OR WITH LITTLE OR NO UNDERWRITING, THE PREMIUMS ARE OFTEN RELATIVELY EXPENSIVE IN RELATIONSHIP TO THE DEATH BENEFIT PROVIDED. FOR INSURANCE PURCHASES, AS WITH ANY OTHER TYPE OF PURCHASES, IT MAY BE TO YOUR ADVANTAGE TO COMPARE PRODUCTS AND PRICES FROM A NUMBER OF SOURCES.

1. PROPOSED INSURED _____
First Name Middle Initial Last Name

Address _____ Social Security No. (Required) _____

City _____ State _____ Zip _____

Date of Birth _____/_____/_____ ❑ Male ❑ Female Telephone (_____)_____

2. SECONDARY ADDRESSEE _____
First Name Middle Initial Last Name

Address _____ Social Security No. (Required) _____

City _____ State _____ Zip _____

Date of Birth _____/_____/_____ ❑ Male ❑ Female Telephone (_____)_____

3.

Amount of Insurance $ _____ **Mode of Premium Payment** ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly ❑ EFT ❑ List Bill **Automatic Premium Loan, if available: ❑ YES ❑ NO**	**Dividends** ❑ Cash ❑ Accumulate at Interest ❑ Reduce Premiums ❑ Paid-Up Additions **Cash with Application** A minimum of **one months'** premium is required. **$** _____

4. BENEFICIARY:
Primary: _____ Relationship _____ Social Security No. _____

Contingent: _____ Relationship _____ Social Security No. _____

5. POLICYOWNER, IF OTHER THAN THE INSURED: **CO-OWNER:**

Name	Relationship		Name	Relationship	
Address	SSN		Address	SSN	
City	State	Zip	City	State	Zip

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

7. Will any policy applied for replace any existing one in whole or in part? ❑ Yes ❑ No If Yes, list Company Name(s) and Policy Number(s):

I agree that: The information above is true and complete to the best of my knowledge and belief; no insurance shall take effect until a policy is issued and the first premium is received by Columbian Mutual Life Insurance Company during my lifetime; and that this application shall form a part of any policy issued.
Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Signature of Proposed Insured	Date	Policyowner, if other than Proposed Insured	Date
Signature of Co-owner	Date	Witness (Agent or Disinterested Third Party)	Date

AGENT'S STATEMENT

THIS STATEMENT MUST BE RETURNED WITH THE APPLICATION

This Statement is Not Part of the Application

To your knowledge, are there any existing life insurance or annuity contracts on the life of the insured? ❑ Yes ❑ No To your knowledge, is the policy applied for intended to replace, in whole or in part, any policy or annuity contract in force in this or any other company? If "yes", submit required forms and explanation. ❑ Yes ❑ No				**HOME OFFICE USE ONLY**
Writing credit on this application shall be given to:				Policy No. Assigned
	Agent's Name	Code	%	
General Agent				Payment Received and Date
District Agent				
Soliciting Agent				
Soliciting Agent				

I hereby declare that this application was secured by me personally and that the only commissions to be paid on any policy issued hereon shall be in accordance with agency contracts applicable thereto.

I further declare that the information supplied by the insured has been truly and accurately recorded on the application, and I unqualifiedly recommend the Proposed Insured for insurance.

Dated at _____ on _____/_____/_____ _____
CITY & STATE MONTH DAY YEAR SIGNATURE OF AGENT

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CONDITIONAL RECEIPT

APPLIES TO GUARANTEED ISSUE POLICIES ONLY

THIS RECEIPT MUST BE DELIVERED TO THE APPLICANT WHEN THE FIRST PREMIUM IS COLLECTED

An amount equal to at least <u>one months' premium</u> must be submitted with the application.

- Make check payable to: Columbian Mutual Life Insurance Company, 5788 Widewaters Parkway, P.O. Box 1056, Syracuse, NY 13201-1056.
- This insurance will be effective from the date on the application provided the first premium has been paid.
- In the event of the death of the proposed insured, the amount of insurance effective under this Conditional Receipt is limited to the modified death benefit.
- This receipt is issued on the condition that any check, draft, or order for payment of money is honored and collectible.

Received from _____ the sum of $_____ paid at the time of signing an insurance application.

The name of the Proposed Insured is: _____

Date _____/_____/_____ Signature _____ Place _____
Month Day Year Licensed Agent City & State