# Application for Individual Life Insurance to:
# COLONIAL LIFE & ACCIDENT INSURANCE COMPANY PO Box 1365 Columbia, SC 29202

**Proposed Insured Section**

| Proposed Insured's Name (First, MI, Last) | Employee ☐ Spouse ☐ Juvenile ☐ | Gender M ☐ F ☐ | Birthdate | Social Security No. |
|---|---|---|---|---|
| Home Address – Street (Not a PO Box) City State Zip Code | | | | Home Phone No.<br>Business Phone No. |

| Date Employed | Occupation/Job Title | Hrs. Worked/Week | Annual Base Salary | State of Birth |
|---|---|---|---|---|
| | | | | |

**Employee Section** (Complete only if Proposed Insured is not the employee)

| Employee Name (First, MI, Last) | Gender M ☐ F ☐ | Birthdate | Relationship to Proposed Insured | Social Security No. | Date Employed |
|---|---|---|---|---|---|
| | | | | | |

**Billing Section**

| Payroll Deduction Employer Name | Employer Address (Street-City-State-Zip) | Employee ID/ Payroll No. | Employee Class | Section/ Dept. No. |
|---|---|---|---|---|
| | | | | |

**Spouse and/or Dependent Children(s) Rider Section** - if additional space is needed, please use the Additional Data Section

| Name (First, MI, Last) | Gender | Birthdate (mm/dd/yyyy) | Relationship | Social Security No. |
|---|---|---|---|---|
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |
| | M ☐ F ☐ | | | |

**Beneficiary Section** – if additional space is needed, please use the Additional Data Section

| Beneficiary's Name (First, MI, Last) | Primary ☐ Contingent ☐ | Age | Benefit % | Relationship to Proposed Insured | Social Security No. |
|---|---|---|---|---|---|
| | | | | | |
| Beneficiary's Name (First, MI, Last) | Primary ☐ Contingent ☐ | Age | Benefit % | Relationship to Proposed Insured | Social Security No. |
| | | | | | |

| Term or Whole Life | Base Plan Code and Premium | Face Amount | Rider Plan Code and Units | Rider Premium | Total Monthly Premium |
|---|---|---|---|---|---|
| Automatic Premium Loan if available for Whole Life? Yes ☐ No ☐ | $ | $ | | | $ |

| Universal Life | Base Plan Code and Target Premium | Face Amount | Rider Plan Code and Units | Rider Premium | Total Monthly Premium |
|---|---|---|---|---|---|
| Option A ☐ B ☐ | $ | $ | | | Planned Premium $<br>$ |

**Life Adjustment**

☐ Existing Policy Number _____ ☐ Increase ☐ Rider Addition ☐ Tobacco to Non-tobacco Policy ☐ Exercising Guaranteed Purchase Option ☐ Option Change (UL only) ☐ Term Life Conversion ☐ Rider Conversion

NOTE: For rider additions, option changes, a change in smoker status, or UL increases, if the Beneficiary Section of this application is completed, this designation *replaces* any other Beneficiary Designation on file for this Policy.

| Eligibility Questions - required for all face amounts | | |
|---|---|---|
| 1. Within the past 12 months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery system? | Yes ☐ No ☐ | |
| 2. Is the Proposed Insured actively working?<br>2.a. If "No", is the Proposed Insured disabled or unable to work? | Yes ☐ No ☐<br>Yes ☐ No ☐ | |
| 3. Is your spouse (if applying for coverage) disabled or unable to work? | | |

| Replacement Section - complete replacement form if required in your state | | | | |
|---|---|---|---|---|
| 4. Does the Proposed Insured have any existing life coverage? If yes, provide details below and complete form if applicable in your state. | | | | Yes ☐ No ☐ |
| 5. Will any life insurance or annuities with this or any other company be replaced or changed if the coverage applied for is issued? If yes, check appropriate box of policy being replaced, modified or discontinued and complete form if applicable in your state. | | | | Yes ☐ No ☐ |
| Insured's Name | Insurance Company Name and Address | Policy Number | Amount of Coverage | Check yes if policy replaced |
| | | | | Yes ☐ No ☐<br>Yes ☐ No ☐<br>Yes ☐ No ☐ |
| 6. Is the Proposed Insured using funds from an existing policy(s) or contract(s) to fund the new policy (1035 Exchange)? If yes, complete the 1035 Exchange form. This question applies to Universal Life Only. | | | | Yes ☐ No ☐ |

| AIDS Section – Required for all face amounts | | |
|---|---|---|
| 7. Have you, or your spouse if applying for spouse coverage, tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)? | Yes ☐ No ☐ | |

| Simplified Issue (SI) | | |
|---|---|---|
| 8. Within the past 12 months, have you, or your spouse if applying for spouse coverage, been hospitalized or missed 5 or more consecutive days of work for any reason other than flu, pregnancy, accidents, allergies, back or knee disorder? If yes, answer Simplified Issue Level One questions. | Yes ☐ No ☐ | |

| Simplified Issue Level One (SI1) | | |
|---|---|---|
| Indicate Your Current: Height_____ Weight_____<br>Indicate Your Spouse's Current: Height_____ Weight_____ | | |
| 9. Within the past 24 months, have you, or your spouse if applying for spouse coverage, used marijuana, cocaine, heroin or any other illicit drug or controlled substance, with the exception of those prescribed for you by a member of the medical profession; received medical advice or been treated by a member of the medical profession for drug and/or alcohol abuse; or been advised by a member of the medical profession to reduce your consumption of drugs or alcohol? | Yes ☐ No ☐ | |
| 10. Within the past 24 months, have you, or your spouse if applying for spouse coverage, been convicted of operating a motor vehicle under the influence of drugs and/or alcohol; or pled guilty to, pled no contest to, or been convicted of or have a charge pending for any felony or misdemeanor, or are you currently on probation or parole? | Yes ☐ No ☐ | |
| 11. Within the past 24 months, have you, or your spouse if applying for spouse coverage, been prescribed 3 or more medications by a member of the medical profession (including diuretic) for high blood pressure; or been prescribed medication for high blood pressure and diagnosed with diabetes by a member of the medical profession? | Yes ☐ No ☐ | |
| 12. Within the past 10 years, have you, or your spouse if applying for spouse coverage, received medical advice or been treated by a member of the medical profession for internal cancer, including leukemia or melanoma of Clark's level III or higher? | Yes ☐ No ☐ | |
| 13. Within the past 5 years have you, or your spouse if applying for spouse coverage, received medical advice or been treated by a member of the medical profession (including medication) for: | Yes ☐ No ☐ | |

| | | |
|---|---|---|
| Heart Attack (MI)/Angina | Congestive Heart Failure/Cardiomyopathy | Emphysema |
| Cardiac/Circulatory Surgery | Systemic Lupus (SLE) Disease | Multiple Sclerosis |
| Peripheral Vascular Disease | Manic Depressive Disorder (Bipolar) | Paralysis |
| Stroke | Schizophrenia | Hepatitis (except A) |
| Chronic Kidney (Renal) Failure | Diabetes (excluding diet controlled and gestational) | |
| Transient Ischemic Attack (TIA) | Chronic Obstructive Pulmonary Disease (COPD) | |

| Owner Section - complete this section if you are naming an owner other than the Proposed Insured or if Proposed Insured is a juvenile | | |
|---|---|---|
| Owner (Name and Address) | Relationship | Social Security No. |
| Contingent Owner (if applicable) (Name and Address) | Relationship | Social Security No. |

## Agreement Section

THE PROPOSED INSURED AGREES AS FOLLOWS:

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law. I have read the application and the answers and statements above are true and complete to the best of my knowledge and belief. Except as otherwise provided in the Conditional Receipt bearing the same date as this application (if any),I understand that this application will not be binding upon Colonial Life & Accident Insurance Company (Colonial) until both: 1) the policy is issued; and 2) the first premium due is paid while the Proposed Insured is alive. Items 1 and 2 must occur while any conditions affecting insurability are the same as described above. I understand that any material misrepresentation may result in claim denial or rescission of coverage for two years after the effective date of coverage. If coverage is rescinded, Colonial's only obligation will be to refund all premiums paid. I understand that the statements and answers in this application are the basis for any policy issued by Colonial, and no information about me will be considered to have been given to Colonial unless it is stated in the application.

I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.

If applicable, I have received and read a copy of the Notice of Insurance Information Practices (which includes MIB, Inc. Disclosure Notice). I hereby authorize Colonial Life & Accident Insurance Company to release information to the MIB.

I acknowledge that ☐ I have ☐ I have not received a full ledger illustration according to the NAIC regulations and I understand that an illustration conforming to the policy as issued (if applicable) will be provided at the time of policy delivery.

I have paid to the agent named in this application $_____ for the first premium due on this policy. This amount is to be applied in accordance with the provisions of the application and the receipt.

I elect to be interviewed if any investigative consumer report is prepared in connection with this application. Yes ☐ No ☐

Signed at: (City)_____ (State) _____ (Date) _____
mm/dd/yyyy

(x)_____
Signature of Proposed Insured

(x)_____
Signature of Owner (if Other than Proposed Insured)

## Agent Section

Agent's Name (If Present)_____
Please Print

Do you have knowledge or reason to believe that the Proposed Insured is intending to replace any existing insurance? Yes ☐ No ☐

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage(s) applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Colonial's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

I certify that ☐ I have ☐ I have not used a full ledger illustration according to the NAIC regulations and I understand that an illustration conforming to the policy as issued (if applicable) will be provided at the time of delivery.

Date_____ (x)_____
mm/dd/yyyy Signature of Licensed Agent

License No._____ Code No._____