

Electronic Application Training

DIGNIFIED CHOICE® FINAL EXPENSE



CFG's Electronic Application

- ❑ Easy-to-use electronic application
- ❑ E-signature and telephone interview (if required) are completed with the Applicant at the time of sale
- ❑ Available 7 a.m. to 1 a.m. Eastern Time
- ❑ Available on computers using Internet Explorer and on iPads using Safari (not supported on other devices at this time)

Advantages of E-Application

- ❑ Immediate submission of application for faster turnaround
 - Policies are issued more quickly
 - Commissions are paid more quickly
- ❑ Eliminates errors
 - Ensures correct / current application is used
 - Ensures that applications are completed in their entirety
 - Ensures that any required supplemental forms are completed
 - Reduces amendments

Important Information to Remember:

1. E-App cannot be used as a means to transmit an application that was completed on paper. **You may not take a paper application and transfer it to E-App at a later time.**
2. **The electronic application must be completed with the Applicant.**
The Proposed Insured must type his or her own name and each party to the application must type his or her own name on the signature screen.

HIPAA regulations prohibit us from accessing any health information without the Applicant's written authorization. We cannot process applications for which the telephone interview was completed prior to the date the application was signed.

E-App Disclosure Packet

The E-App Disclosure Packet contains all printed disclosures you may need during the sale. Packets for your state are available online or may be ordered from General Services at 800-423-9765, ext. 7197. When ordering packets, please request Form No. 5354CFG followed by your state abbreviation, i.e., 5354CFG-NC.

- ☐ The cover letter explains the E-App process to the client.
- ☐ You must leave a paper copy of all required forms with the applicant.
- ☐ When signing the E-App, you will be required to certify that you have provided all required disclosure documents to the applicant in paper form.

Completing a New Application

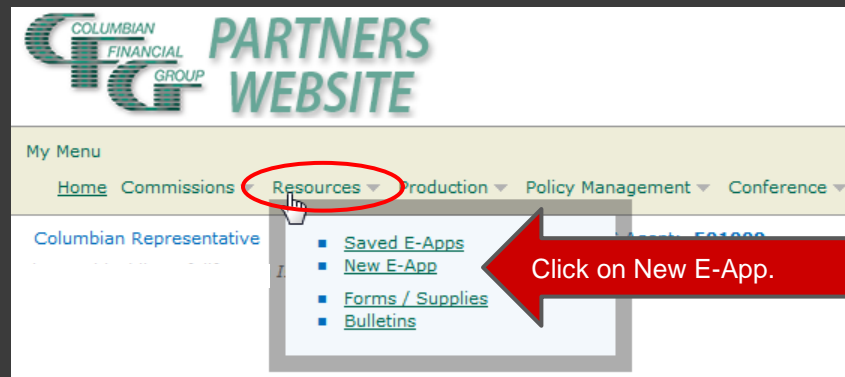
Log in as you normally do.

For computer, use Internet Explorer.

You must be in the Final Expense market class.

Business for Final Expense Change

For iPad, use Safari. You may be prompted to go to Settings/Safari. In the General section, turn the "Block Pop-Ups" slider to "off."



Click on New E-App.

Begin Application

Required fields are indicated by a yellow background.

Agent Account 014 - Columbian Repres

State NC

Product Final Expense v5

Proposed Insured Name Harvey Smith

First MI Last Suffix

You must be appointed to do business in the state of application prior to submitting an E-App for that state.

[Continue](#)

Fields where entry is required are indicated by a yellow background.

E-App Authorization Screen

Check the box to indicate that all parties understand that they will be able to electronically sign the application and that their electronic signature will be legally binding.

Columbian Representative	CFG Agent: 501009-014	Application ID: 13043959 Proposed Insured: Harvey Smith	Market Class: Final Expense Product: Final Expense State: NC Application Form ID No.: A615-CL
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Authorization

i Application 13043959 started.

⚠ **Electronic Signature**

At the end of this application process the agent and other required parties, such as Insured/Owner, may elect to electronically sign the application. Please acknowledge the use of an Electronic Signature by checking the box below.

☒

 All parties understand that we will be able to electronically sign this application to indicate acceptance of its terms, and that our electronic signatures will be legally binding, just as if we had signed the paper versions using pen and ink.

Fields where entry is required are indicated by a yellow background.

Click **Continue** to proceed.

➔ **Continue**

Proposed Insured Screen

Application Entry

[Proposed Insured](#)

[Questionnaire](#)[Coverage](#)[Owner](#)[Beneficiary](#)[Miscellaneous](#)[Payment](#)[Agents](#)[Replacement](#)

Proposed Insured

Insured Name

First MI Last Suffix

Social Security Number

or Green Card Number If providing a green card number, a U.S. Driver's License number must be provided and the maximum policy face amount is \$15,000.

Gender

State of Birth/Country of Birth

Date of Birth (MM/DD/YYYY)

Requested Effective Date (MM/DD/YYYY)

Age

Address

Street City State Zip

Note: We are unable to offer coverage if the proposed insured's primary state of residence is AK, AL or MS.

Primary Phone

Number Type

Alternate Phone

Number Type

Email maximum 50 characters

Height

Feet Inches

Weight lbs.

Driver's License

State Number

Backdating up to 6 months to save age is allowed. All premiums must be submitted with the application. Indicate the requested effective date.

For Draft First Premium, the effective date must match the first draft date. For "Day of the month" draft, the first draft must be within 30 days of the application date. For "Week/Day of the month" draft, the first draft must be within 35 days of the application date.

Questionnaire Screen Part 1

Questionnaire

PART 1 (If any question in this section is answered "YES," DO NOT SUBMIT THE APPLICATION)

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? NO
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? NO
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? NO
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? YES

If any PART 1 question is answered "yes," coverage will be declined. At this point you will be able to return to the application to correct any errors or withdraw the application.

Insurability Information

We're sorry, but we are unable to issue a Final Expense policy for the Proposed Insured at this time. As a result, this application is declined.

You may [return to the application form](#) or [withdraw the application](#).

Questionnaire Screen Part 2

PART 2 (If any question in this section is answered "YES," the Proposed Insured will be considered for the Classic Security Graded Benefit Plan.)

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? NO
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)? NO
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)? NO
4. During the last six (6) months have you been diagnosed by a member of the medical profession as having a heart attack? YES

If any PART 2 question is answered "yes," the Proposed Insured will be considered for a Classic Security plan only. The remaining health questions will be unnecessary and will disappear from the screen.

Questionnaire Screen Part 3

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.)

If any PART 3 question is answered "yes," the Proposed Insured will be considered for Classic Advantage. If two or more questions are answered "yes," the Proposed Insured will be considered for Classic Security.

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)?

NO

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?

NO

b. Multiple Sclerosis, Parkinson's Disease, schizophrenia, brain tumor or have you been hospitalized or institutionalized for a mental or nervous disorder?

NO

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?

NO

b. Been convicted of three (3) or more moving violations, or been convicted of driving under the influence of alcohol or drugs?

NO

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?

NO

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?

NO

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?

NO

Questionnaire Screen Part 4

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.

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?

- If any PART 4 question is answered "yes," the Proposed Insured will be considered for Classic Select.
- If two or more questions are answered "yes," the Proposed Insured will be considered for Classic Advantage.
- If all questions in all sections are answered "no," the Proposed Insured will be considered for Classic Elite.

Questionnaire Screen Part 5

Part 5

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

Date of last visit

6 2015

Month

Year

Name of Physician or Medical Facility

Dr. Orwell

Address (Street)

Address (City)

Raleigh

Address (State)

NC

Address (Zip)

Reason Consulted

Headache

Treatment/Diagnosis

Antibiotic / Sinus Infection

- Proposed Insureds age 60 - 70 who have not had a medical consultation within the past five years will be considered for the Classic Select Plan.
- Proposed Insureds age 71+ who have not had a medical consultation within the past three years will be considered for the Classic Security plan.

Replacement Questions

Be sure to answer the replacement questions at the end of the questionnaire. If the first question is answered “No,” the second answer will be provided automatically.

REPLACEMENT:

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?

Fields where entry is required are indicated by a yellow background.

Coverage Screen

Application Entry

- ✓ [Proposed Insured](#)
- ✓ [Questionnaire](#)
- [Coverage](#)
- [Child Supplemental](#)
- [Owner](#)
- [Beneficiary](#)
- [Miscellaneous](#)
- [Payment](#)
- [Agents](#)

Coverage

Plan of Insurance Classic Elite

Tobacco Status NO 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?

Automatic Premium Loan Yes

Amount of Insurance (Face Amount) 15000

☒ Children's Term Insurance Rider

Children's Rider Amount: 2.5 Units

Children to Insure 2 (Children are natural born children, stepchildren, legally adopted children, grandchildren, step grandchildren, legally adopted grandchildren, great grandchildren, step great grandchildren and legally adopted great grandchildren.)

☐ Accidental Death Benefit

☐ Accelerated Death Benefit

Fields where entry is required are indicated by a yellow background.

If applying for Children's Term Insurance Rider, choose the amount (1 Unit = \$1,000) and the number of children to be covered.

Select coverage, then click **Calculate** to get modal premiums.

Premiums \$93.10 \$283.58 \$556.47 \$1,070.13
Monthly Quarterly Semi-Annual Annual

Calculate

Details

Save **Cancel**

Child Supplemental

Child Supplemental

Children Details

George Smith

Sara Smith

Enter information for each child.
Click the tabs to add children.

Name

George

MI

Smith

Suffix

First

MI

Last

Suffix

Gender

Male



Social
Security
No.

DOB

Age

8

Last

Birthday

If the exact date of birth is not
available, enter the child's age.

Address

Street

City

Select One



State

Zip

Phone

Have you completed all children details?

YES



When complete, click YES.

Children's Health History

CHILDREN'S HEALTH HISTORY

1. Has any child proposed for insurance 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 any Proposed Insured Child tested positive for Human Immunodeficiency Virus (HIV)?

NO

2. Has any child proposed for insurance ever used or received treatment, advice or counseling from a physician or other practitioner relating to the usage of alcohol, heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines, or other similar drugs except as prescribed by a physician?

NO

3. Has any child proposed for insurance ever been diagnosed or treated (including taking medication) for high blood pressure, heart or circulatory disorder, cancer, mental disorder, mental retardation, Down's Syndrome, muscular dystrophy, spina bifida, cystic fibrosis, kidney or liver disease, diabetes, sickle cell anemia, seizures, cerebral palsy, paralysis, had or been recommended for an organ transplant or been hospitalized for asthma or any respiratory disorder in the past twelve (12) months?

YES

YES Answer Applies to Children Checked Below

☐ George Smith ☒ Sara Smith

If a health question is answered "yes," check appropriate box to identify the child the "yes" answer applies to.

This child will be ineligible for coverage. You will be notified that the Children's Rider count has changed and will have the option to return to the application or withdraw the application.

Insurability Information

CTIR Children count changed. Premium and benefit options may have changed.

You may [return to the application form](#) or [withdraw the application](#).

The maximum number of eligible children is 20. Children who are ineligible for coverage do not count toward the maximum.

Children's Rider Beneficiary

If the Primary Beneficiary will be other than the base policy proposed insured, uncheck this box and complete the information below.

☐ Primary Beneficiary is the proposed insured

Relationship

Mother

Beneficiary Name	Lucinda		Smith			
	<small>First</small>	<small>MI</small>	<small>Last</small>	<small>Suffix</small>		
Beneficiary Social Security No.	222-33-4444					
Beneficiary DOB						
Beneficiary Address				Select One		
	<small>Street</small>	<small>City</small>		<small>State</small>	<small>Zip</small>	
Beneficiary Phone Number						

If there will be a contingent beneficiary, check this box and complete the information that appears.

☐ Child Rider has contingent beneficiary

Be sure to save all changes.

If there will be more than one Children's Rider beneficiary, please use the Special Remarks section on the Miscellaneous screen to indicate the additional beneficiary.

Owner Screen

Owner

☐ Owner is the proposed insured

Owner Name
First MI Last

Social Security No.

or Green Card Number

Date of Birth (MM/DD/YYYY)

☐ Address is the proposed insured address


Address
Street City State Zip

Primary Phone
Number Type

Alternate Phone
Number Type

Email maximum 50 characters

Relationship to Proposed Insured

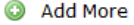


Complete the yellow fields if the owner will be other than the insured. Enter a Social Security Number or Green Card Number.

Beneficiary Screen

Beneficiary

Primary Beneficiary

 Add More

1

Name

First MI Last Suffix

Relationship

Percentage

Primary Phone

Number Type

Alternate Phone

Number Type

Email maximum 50 characters

Address

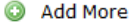
Street City State Zip

Date of Birth (MM/DD/YYYY)

SSN

or Green Card Number

Contingent Beneficiary

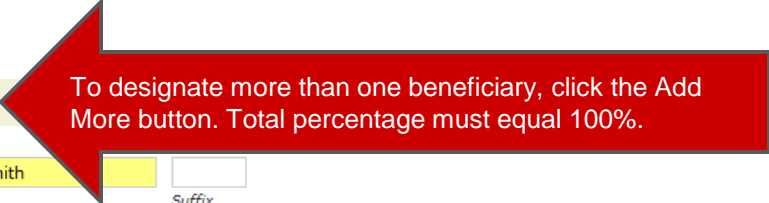
 Add More

1

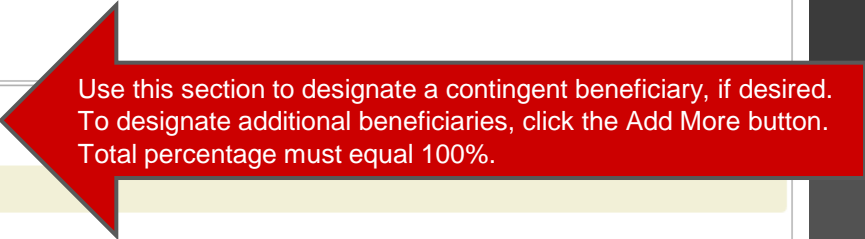
Name

First MI Last Suffix

Relationship



To designate more than one beneficiary, click the Add More button. Total percentage must equal 100%.



Use this section to designate a contingent beneficiary, if desired. To designate additional beneficiaries, click the Add More button. Total percentage must equal 100%.

Miscellaneous Screen

Use this screen to specify where the policy will be mailed, designate a secondary addressee if desired, and make any special requests or remarks.

Miscellaneous

Mail Policy To

OWNER

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

Special Requests and Remarks

Signing Location

Raleigh

Signing City

NC

Signing State

Payment Screen

Payment

Payment Method ☒ Cash with App (immediate draft) and ongoing EFT
☐ Draft First Premium (on specified future date) and ongoing EFT
☐ Cash with App (immediate draft) and ongoing Direct Bill

Ongoing EFT Mode ☒ Monthly ☐ Quarterly ☐ Semi Annual ☐ Annual

Modal Premium

Initial Draft Amount

Ongoing Payment Bank Routing Number

Ongoing Payment Bank Name

Ongoing Payment Bank Account Number

Retype Ongoing Payment Bank Account Number

Ongoing Payment Bank Account Type ☒ Checking ☐ Savings

Account Owner/Payer is: ☒ Insured ☐ Owner ☐ Other

Draft Schedule ☒ Day of month ☐ Week/Day of the month

I request withdrawal of payments on day beginning in the month of

Withdraw from existing account? ☒ Yes ☐ No

Fields where entry is required are indicated by a yellow background.

Premiums	\$93.62	\$285.17	\$559.59	\$1,076.13
	Monthly	Quarterly	Semi-Annual	Annual
<input type="button" value="Calculate"/>				
<input type="button" value="Details"/>				

For "Day of the month" draft, the first draft must be within **30** days of the application date. For "Week/Day of the month" draft, the first draft must be within **35** days of the application date. The policy effective date must match the date the premiums begin.

Agents Screen

Agents

Does this applicant have any existing life insurance or annuities?

NO

Is this insurance intended to replace, in whole or part, any life insurance or annuities?

NO

Has the Telephone Interview been completed?

YES

Interview Reference ID Number

123456

Agent Name

Columbian Representative

Agent Number

501009

Agent Shares %

100

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

I have provided required disclosure documents related to this application to the applicant in paper form. Agent, initial here to certify.

CR

Second Agent Name (if splitting)

Second Agent Number (if splitting)

Second Agent Share % (if splitting)

Agent Address

101 Main Street

Street

Raleigh

City

NC

State

12345

Zip

Agent Contact

(555) 666-7777

Agent Phone Number

If applying for Full Benefit, please complete the telephone interview to expedite processing. Let the interviewer know that you are calling for our e-signature product. Enter the interview reference ID number here.

By initialing here, you are certifying that you have provided the Applicant with all required disclosures from the E-App Disclosure Packet.

Telephone interviews obtained prior to the date of the E-Signatures will not be accepted and will result in delays.

Review Summary

Application Entry

- ✓ [Proposed Insured](#)
- ✓ [Questionnaire](#)
- ✓ [Coverage](#)
- ✓ [Child Supplemental](#)
- ✓ [Owner](#)
- ✓ [Beneficiary](#)
- ✓ [Miscellaneous](#)
- ✓ [Payment](#)
- ✓ [Agents](#)

When all sections have been completed and have a green check mark, click the Review Summary button.

Premiums	\$93.62	\$285.17	\$559.59	\$1,076.13	
	<i>Monthly</i>	<i>Quarterly</i>	<i>Semi-Annual</i>	<i>Annual</i>	
<input type="button" value="Calculate"/>					<input type="button" value="Details"/>

Review Summary

Review the summary with the Proposed Insured. At this point, you may choose to edit, withdraw or prepare the application for signing.

Summary of Coverage Applied For

Proposed Insured: Harvey Smith

Age: 67

Gender: MALE

Tobacco Status: NO

Plan Name: Classic Elite

Policy Face Amount: \$15,000.00

Riders:

- Children's Term Insurance Rider 2.5 units on 1 Children

Requested Effective Date: 09/01/2016

Payment Method: Cash with App (immediate draft) and ongoing EFT

Initial Premium Amount: \$93.62 will be drafted immediately upon receipt of application.

Ongoing Premium Payments: \$93.62 will be payable beginning on 10/01/2016 and will be payable Monthly by bank draft on the 1st

This summary is based on the coverage applied for and is not guaranteed.

☒ 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.

Classic Select
Classic Advantage
Classic Security

☐ Adjust face amount to match premium?

 Edit  Withdraw  Prepare For Signature

Checking this box will allow the policy to be issued without a signed amendment if the plan issued differs from the plan applied for.

Application Documents Screen

Review the forms to verify that information is correct.

If using iPad, you will need to allow the pop-up window to view the documents.

This site is attempting to open a pop-up window

Block

Allow

Application Documents

⚠ Attention

The application forms shown below have been filled out with the answers you provided on the previous screens. Please review the forms and verify that the information on them is correct. If any of the information on the forms is not correct, you may click the Edit button now to return to the application entry screen and the forms shown below will be discarded.

Pay special attention to the portions of the forms where your signatures are requested. After you review the forms, you will be asked to accept the terms of this application by typing your name on the screen below. You agree that by typing your name on this electronic application where indicated below, you are signing this form indicating your agreement to be bound to the terms and conditions in this form. You agree that typing your name is your legal signature on this document.

APPLICATION FOR INDIVIDUAL WHOLE LIFE INSURANCE POLICY

MAIL POLICY TO: ☒ Owner ☐ Agent

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE:
PO Box 1381 • Binghamton, NY 13902-1381
Reference ID: 123456

1. PROPOSED INSURED						
First Name Harvey		Middle Initial	Last Name Smith		Social Security No./Green Card No. 123-45-6789	
Sex <input checked="" type="checkbox"/> M <input type="checkbox"/> F	Age (Last Birthday) 68	Date of Birth (MM/DD/YYYY) 12/24/1948	State (USA) / Country of Birth North Carolina	Home Phone: (222) 333-4444 Email:	Cell Phone:	
Home Address/Apt. #, Street 3 Easy Street				City Raleigh	State NC	Zip Code 12345

Each signer must type his or her own signature.

Turn your laptop to each signer so they can review the documents and type their own signature. When all signature lines are completed, click the **Sign and Review** button to review the signed documents before submitting or click the **Sign and Submit** button to submit without reviewing the signed documents.

⚠ Electronic Signature

All parties to this application for insurance, please type your names on the indicated lines below.

You agree that you have read this entire form completed with your answers to the best of your knowledge and belief.

You agree that by typing your name on this electronic application where indicated by agreement to be bound to the terms and conditions in this form. You agree that typ

Required Signatories:

Proposed Insured *	Harvey Smith
Owner *	Jane Smith
Ongoing Payor *	Harvey Smith
Licensed Agent *	Columbian Representative

Fields where entry is required are indicated by a yellow background.

Edit

Sign and Review

Sign and Submit

Please note that some states require the signature of proposed insured children over a certain age. If the child is unavailable to sign, type "not available" in the signature space for the child. The Company will ask the policyowner to obtain the signature at issue.

Submitted Applications

The application will appear as “Submitted” in your Applications list.

My Applications




Application 13043959 for Harvey Smith successfully submitted.

[Begin Application](#)

Actions	Application	Insured	Product	Created	Last Updated	Status	Application Image
	13043959	Harvey Smith	Final Expense	3/20/2017 4:40 PM	3/20/2017 5:23 PM	Submitted	Signed Documents

You may review or save the signed application documents by clicking on “Signed Documents” and selecting the document you wish to open or save.

Document List for Harvey Smith

Document Type
 APPLICATION
 EAPP ELECTRONIC AUTH FORM
 EFT AUTHORIZATION FORM

[<< Return to Saved E-Apps](#)

Hardware questions - please contact:

- CFG Help Desk, 800-423-9765, extension 6333

Software questions - please contact:

- CFG Sales Support, 800-423-9765, extension 7582
- Beth Keeley, 800-347-0960, extension 7452
- Liza Cianciosi, 800-423-9765, extension 4246
- Michael Beacham, 800-347-0960, extension 7581

Columbian Mutual Life Insurance Company
Home Office: Binghamton, NY

Columbian Life Insurance Company
Home Office: Chicago, IL
Administrative Service Office: Binghamton, NY 13902

Columbian Life Insurance Company is not licensed in every state.

Refers to Policy/Rider Forms 1F156, 1F156-CL, 1F157-CL, 1F158, 1F158-CL, 1F159, 1F159-CL, 1H884, 1H884-CL, 1H885, 1H885-CL, 1H864, 1H864-CL, 1H865 and 1H865-CL or state variation. Product specifications and availability may vary by state.
Product/Rider specifications and availability may vary by state.