

**APPLICATION FOR
SINGLE PAY
LIFE INSURANCE**

- COLUMBIAN MUTUAL LIFE INSURANCE COMPANY**
VESTAL PARKWAY EAST, PO BOX 1381, BINGHAMTON, NY 13902-1381
- COLUMBIAN LIFE INSURANCE COMPANY**
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: PO BOX 1381, BINGHAMTON, NY 13902-1381

1. PROPOSED INSURED:				
(a) Name: First Middle Last	(b) Birth Date Mo/Day/Yr	(c) Age Nearest	(d) Sex: <input type="checkbox"/> Female <input type="checkbox"/> Male	(e) Social Security No.
(f) Home Address:	(g) City	State	Zip	

2. OWNER: (COMPLETE ONLY IF OWNER IS OTHER THAN PROPOSED INSURED)

(a) Name (First, Middle, Last): _____

(b) Address: _____



3. BENEFICIARY DESIGNATION:

(a) Primary (Full Name & Address)	Relationship To Insured
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4. POLICY INFORMATION:

(a) PLAN OF INSURANCE: SINGLE PAY LIFE <input type="checkbox"/> BB <input type="checkbox"/> ASTY <input type="checkbox"/> TAL <input type="checkbox"/> Other: _____	(b) PREMIUM AMOUNT PAID \$ _____	(c) AMOUNT OF INSURANCE \$ _____	(d) OPTIONAL BENEFIT: <input type="checkbox"/> Accidental Death Benefit
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5. TYPE OF CONTRACT: Group Individual

6. DIVIDEND OPTION: Paid In Cash Accumulate At Interest Reduce Premium Paid Up Additions

7. REPLACEMENT:

Is this application for insurance intended to replace any life or health insurance or annuity now in force? **YES NO**
(If "YES", give full details in "Special Request or Remarks")

8. SPECIAL REQUESTS OR REMARKS: **9. HOME/PRINCIPAL OFFICE ENDORSEMENTS:**

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10. CONDITIONS RELATING TO THE APPLICATION & SIGNATURES:

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/certificate issued. **I understand that no insurance applied for will be effective until the premium is paid. A copy of this application is my receipt.** All premium checks must be made payable to the Company. Do not make check payable to the Agent or leave the payee blank.

I have read and acknowledge the applicable fraud notice required by state law.

X _____ Date	X _____ Proposed Insured
_____	X _____ Applicant/Owner (If other than the Proposed Insured)

REPORT OF LICENSED AGENT:

Is this insurance intended to replace any life or health insurance or annuities in this or any other company? **YES NO**
(If "YES", submit any special forms required by the state in which the application is signed)

_____	X _____
Name of Agency Office (Print)	Licensed Agent
_____	_____
Agency Number	Agent Number
_____	_____
Agent's State License Identification Number (In jurisdictions where required)	