



Electronic Application

AGENT TRAINING



Columbian's eApp

- Easy-to-use electronic application
- E-signature completed with the applicant at the time of sale
- Available 7am to 1am Eastern Time
- **For best results, use laptop, computer, or tablet with adequate screen size.** Not recommended for use with cell phone.
- iPad users - If you experience problems using Safari, please use Google Chrome.



eApp Advantages

- Built-in Risk Qualifier saves time
- Point of Sale underwriting decision option
- Immediate submission of application for faster turnaround
 - Policies issued more quickly
 - Commissions paid more quickly
- Eliminates errors
 - Ensures that the correct application is used
 - Ensures that information is not missing
 - Ensures that any required supplemental forms are completed
- Reduces amendments



Important Reminders

- eApp cannot be used to transmit an application that was completed on paper. **You may not take a paper application and transfer it to eApp at a later time.**
- **The electronic application must be completed with the applicant.** The Proposed Insured must enter his or her own signature.
- HIPAA regulations prohibit us from accessing health information without the applicant's written authorization



Required Disclosure Documents

The eApp Disclosure Packet contains any printed disclosures you may need during the sale.

- You must leave a fully completed paper copy of any required forms with the applicant.
- When signing the eApp, you must certify that you have provided all required disclosure documents to the applicant in paper form.

eApp Disclosure Packets for your state are available online or may be ordered from General Services. Please request Form No. 6199CL followed by your state abbreviation.

Completing a New eApp



COLUMBIAN FINANCIAL GROUP PARTNERS WEBSITE

My Menu

- Home
- Commissions
- Resources
- Production
- Policy Manage

Agent Home

Final Expense software

- Saved eApps (2016 produ
- Begin eApp (2016 produ
- eApp (new product)**
- Forms / Supplies
- Bulletins
- Document Upload
- Upload History
- Managed Agent Contact Listing

Log in to the Partners Website

Select Resources / eApp (new product)

COLUMBIAN FINANCIAL GROUP

Welcome **Columbian Agent**

Search >

New eApp >

Select New eApp

New eApp

State: NC North Carolina

Product List

Product	Type	Market Class
Final Expense (2020)	Whole Life	Final Expense
SafeShield (2020)	Term Life	Simplified Issue Term

+ Create **Create**

Select State

Select Product

Create

Risk Qualifier



SafeShield (2020)

- ✖ Risk Qualifier
- ✖ Proposed Insured
- ✖ Beneficiaries
- ✖ Owner
- ✖ Payment Information
- ✖ Miscellaneous
- ✖ Report of Licensed Agent
- ✔ eApp Review
- ✖ Finish

Premiums Details

Monthly (EFT) \$--

Quarterly \$--

Semi-Annual \$--

Annual \$--

Calculate
Details

Risk Qualifier

Height (Ft)

Select

Height (In)

Select

Weight (lbs)

← Required information in yellow

Are you currently employed? Yes No

Have you ever been diagnosed by a member of the medical profession as having or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

Are you currently:

a. Bedridden or confined to any hospital, nursing home, or other medical facility, or using oxygen or a home catheter? Yes No

b. Permanently using any of the following: walker, wheelchair, or electric scooter? Yes No

In the past five (5) years, have you been recommended by a member of the medical profession for an organ or bone marrow transplant, or ever had or received treatment or required follow-up for a heart, lung, liver, kidney or bone marrow transplant, or ever had or received treatment or required follow-up for an amputation due to disease, or within the last twelve (12) months, received kidney dialysis? Yes No

Have you ever been diagnosed by a member of the medical profession or received treatment for a stroke (CVA), transient ischemic attack (TIA), congestive heart failure, mental retardation, Down's Syndrome, Alzheimer's disease or dementia, or received a cardiac defibrillator implant? Yes No

In the past ten (10) years, have you been diagnosed by a member of the medical profession, received treatment, or required follow-up for: Schizophrenia, bipolar disorder, major depression, Parkinson's disease, Multiple Sclerosis, cardiomyopathy, or received a cardiac pacemaker implant? Yes No

← Color indicates eligibility

Risk Qualifier

Interactive Risk Qualifier asks knockout questions first. Answers generate warnings as needed.



SafeShield (2020)

Height (Ft) 5 Height (In) 3 Weight (lbs) 117

Are you currently employed? Yes No

Occupation Other Other - Occupation Engineer

Have you ever been diagnosed by a member of the medical profession as having or tested positive for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? Yes No

Warning
Client does not meet eligibility requirements. Use Home Button to return to Dashboard.

[Lock Application](#) [Edit Answer](#)

Knockout question

Locks application from editing

Tap or click to correct answer

Choose “Edit Answer” if button was selected by mistake. The “Lock Application” button will lock the application from editing.

Risk Qualifier

A warning will appear if underwriting review will be needed.



Have you experienced any unexplained weight loss of more than 10 lbs. in the last year? Yes No

Please provide details:

a. In the past five (5) to ten (10) years, have you been diagnosed by a member of the medical profession, received treatment, or required follow-up for cancer (other than basal cell or squamous cell carcinoma of the skin)? Yes No

Warning

Underwriting review will be needed. We will make every effort to issue the policy as quickly as possible.

[Lock Application](#) [Continue With Questions](#)

Locks application from editing

Tap or click to continue

Click for details.

⚠ **?**

Premiums Details

Monthly (EFT)	\$--
Quarterly	\$--
Semi-Annual	\$--
Annual	\$--

[Calculate](#) [Details](#)

Underwriting Details **✕**

Underwriting review will be needed due to the following questions.

- Have you experienced any unexplained weight loss of more than 10 lbs. in the last year?

[OK](#)

Risk Qualifier

Answering “Yes” to the question regarding smoked marijuana will automatically change the rate class to Tobacco.



Have you smoked marijuana in the past twelve (12) months? Yes No

Date of Birth:

Age:

Gender:

Plan of Insurance:

Rate Class:

Amount of Insurance (Face Amount):

Tobacco premiums apply if the applicant has smoked marijuana in the past 12 months.

Risk Qualifier

Questions associated with the Chronic Illness Rider will appear only if applying for the rider.



Accelerated Death Benefit – Chronic Illness

Do you require any assistance or supervision to perform any of the following activities of daily living: bathing, eating, dressing, toileting, walking, transferring to or from bed or chair, or maintaining continence?

Yes

No

Have you ever been diagnosed by a member of the medical profession for, consulted with, been tested for, or advised to be tested or treated by a member of the medical profession for any of the following:

a. Memory loss, cognitive impairment, organic brain syndrome?

Yes

No

b. Fractures due to osteoporosis, numbness, tremors, imbalance or any condition which limits motion or mobility?

Yes

No

Risk Qualifier

After making face amount and rider selections, the calculator will display premiums for all modes.



SafeShield (2020)

Risk Qualifier

- Proposed Insured
- Beneficiaries
- Owner
- Payment Information
- Miscellaneous
- Children Proposed for Insurance
- Report of Licensed Agent
- eApp Review
- Finish
- 15 YT Non-ROP**

Premiums Details

Monthly (EFT)	\$14.36
Quarterly	\$43.75
Semi-Annual	\$85.85
Annual	\$165.09

Date of Birth: 08/16/1987 | Age: 32 | Gender: Female

Plan of Insurance: 15 YT Non-ROP | Rate Class: Non-Tobacco | Amount of Insurance (Face Amount): \$25,000

Accidental Death Benefit
 Guaranteed Purchase Option
 Waiver of Premium (Disability)
 Children's Term Insurance Rider

Number of children: 2 | Number of units: \$2,500

Accelerated Death Benefit - Terminal Illness
 Accelerated Death Benefit - Critical Illness
 Accelerated Death Benefit - Chronic Illness

Do you require any assistance or supervision to perform any of the following activities of daily living: bathing, eating, dressing, toileting, walking, transferring to or from bed or chair, or maintaining continence? Yes No

Have you ever been diagnosed by a member of the medical profession for, consulted with, been tested for, or advised to be tested or treated by a member of the medical profession for any of the following:

a. Memory loss, cognitive impairment, organic brain syndrome? Yes No

b. Fractures due to osteoporosis, numbness, tremors, imbalance or any condition which limits motion or mobility? Yes No

Tap or click to calculate premiums

Premium Details

15 YT Non-ROP	Monthly (EFT)	Quarterly	Semi-Annual	Annual
Base Policy	\$7.72	\$23.52	\$46.15	\$165.09
Guaranteed Purchase Option	\$4.12	\$12.56	\$24.71	\$96.84
Children's Term Insurance Rider	\$1.04	\$3.18	\$6.35	\$24.71
Accelerated Death Benefit - Terminal Illness	No charge	No charge	No charge	No charge
Accelerated Death Benefit - Critical Illness	No charge	No charge	No charge	No charge

Base policy and rider premiums shown separately

Proposed Insured

Enter the Proposed Insured's name to continue.



Risk Qualifier Status

Based on the information entered, this client may be eligible for a SafeShield plan. To continue with the application process, please enter the client's name and confirm that the information previously entered is true and correct, as these answers will become part of the application.

First Name Last Name

Tap or click to continue

Name carries forward

Proposed Insured

First Name Middle Name Last Name Suffix

Gender Date of Birth Age

Social Security No. Or Green Card State (USA)/Country of Birth

Gender, DOB and age carries forward from Risk Qualifier

Contact Information

Phone Number Phone Number Type eMail

Street Apt/Suite

City State Zip Code

Annual Income Total Household Annual Income

2 of 10

Complete all required fields and tap or click Next

Beneficiaries

Name, relationship and Social Security Number or Green Card Number are required. Additional information is optional.



Primary Beneficiary #1

Beneficiary Type
Individual

First Name
John

Suffix
Select

Relationship to Proposed Insured
sp
Spouse

Date of Birth
MM/DD/YYYY

Social Security No.
222-33-3444

Green Card

Contact Information

Phone Number

Phone Number Type
Home

Street

Apt/Suite

City

State
Select

Zip Code

Beneficiary %
100%

+Add Primary Beneficiary

Contingent Beneficiary

+Add Contingent Beneficiary

Start typing to bring up options.

Option to reuse the Primary Insured's address.

Tap or click to add beneficiary

Tap or click to add contingent beneficiary

Owner

Select from drop down list or choose Other to name a different Owner.



Owner

Owner is

Jane Doe
John Doe
Other

Role: Proposed Insured

Previous 4 of 10 Next

Select from list or choose Other.

Owner

Owner is

Other

Role: Other

Owner Type

Individual

First Name

Middle Name

Last Name

Suffix

Relationship to Proposed Insured

Select

Social Security No.

Green Card

Or

Contact Information

Street

Apt/Suite

Reuse Address

City

State

Zip Code

Expands if "Other" is selected



Payment Options

The initial premium can be drafted:

- When the policy is issued
- At a future specified date (within 35 days of application date)
- Immediately upon receipt of the application

For Draft on Issue or Immediate draft, do not change the Effective Date. Select one of the options highlighted in yellow.

Payment Frequency

Effective Date

Payment Frequency

Draft on Issue - Draft initial premium from the account below on date of policy issue, if there are no pending application requirements.

Draft initial premium from the account below at a future date. (The first draft must be within 35 days of the application date). **If you select an initial premium draft date in the future, you will not have potential coverage until that date under the Conditional Receipt. Insurance age will be calculated as of the date the premium is drafted.**

Immediate Draft - Draft initial premium upon receipt of the application at Columbian's office, from the account below. **Please note that your bank account may be debited the same day your agent submits this authorization.**

Initial Premium

Modal Premium

Do not change for Draft on Issue or Immediate Draft

Select Draft on Issue or Immediate Draft



Payment Options - Future Draft

To have the initial premium drafted at a future date, set the Effective Date to the date of the first draft and select the highlighted option. When a future effective date is selected, the other draft options are disabled.

The effective date must be within 35 days of application date.

Payment Frequency

Effective Date
12/22/2019

Payment Frequency
Monthly

Draft on Issue - Draft initial premium from the account below on date of policy issue, if there are no pending application requirements.

Draft initial premium from the account below at a future date. (The first draft must be within 35 days of the application date). **If you select an initial premium draft date in the future, you will not have potential coverage until that date under the Conditional Receipt. Insurance age will be calculated as of the date the premium is drafted.**

Immediate Draft - Draft initial premium from the account below on receipt of the application at Columbian's office, from the account below. The account may be debited the same day your agent submits the application.

Initial Premium

Modal Premium
\$12.88

To draft first premium at a future date, set Effective Date to date of first draft.

Must be chosen for future effective date



Payment Options - Backdating

Policies may be backdated up to six months to save age. To backdate, set the Effective Date to the desired date.

Back premiums to the Effective Date must be paid.

Future draft date is not available when backdating.

Payment Frequency

Effective Date *Enter the desired date*
08/25/2019

Payment Frequency
Monthly

Draft on Issue - Draft initial premium from the account below on date of policy issue, if there are no pending application requirements.

Draft initial premium from the account below at a future date. (The first draft must be within 35 days of the policy issue date.) *Disabled for backdating* **an initial premium draft date in the future, you will not have potential coverage under the Conditional Receipt. Insurance age will be calculated as of the date the premium is drafted.**

Immediate Draft - Draft initial premium upon receipt of the application at Columbian's office, from the account below. **Please note that your bank account may be debited the same day your agent submits this authorization.**

Initial Premium

Modal Premium
\$12.88

Initial Premium Amount *Enter the amount to be drafted*

eApp will calculate back premium → The suggested Initial Premium Amount for a back dated policy is \$51.52. This will pay the policy to 12/25/2019.

Subsequent Premiums

For EFT payments, choose a day between the 1st and the 28th of the month or a day of week / week of month combination to coincide with bank account deposits.



Subsequent Premium Payments

EFT Direct Bill (Not available for monthly Payment Frequency)

Choose a specific day (1st - 28th) Choose a specific week and day of the month

Select Week: Select Day: Beginning in the month of:

Bank Account Authorization

Transit / Routing Number (must have 9 digits):

Financial Institution:

Checking Savings

Account Number (may have up to 17 digits):

Re-enter Account Number (may have up to 17 digits):

SOCIAL SECURITY BENEFIT AUTHORIZATION: if checked, I authorize the Company to adjust the date of withdrawal from my bank account to match my Social Security Benefit Deposit



New **Social Security Benefit Authorization** allows premiums to be drafted the same day Social Security benefit is deposited, even when the deposit occurs early due to a holiday.

Miscellaneous

Select the delivery preference, answer the replacement questions, enter special remarks and elect secondary addressee, if desired.



Miscellaneous

Policy Delivery Options and Correspondence Preferences

Deliver To: Owner Agent

Policy Correspondence: US Mail Email

Not yet available

"Yes" answers will trigger any necessary additional questions

Replacement Questions - Primary Insured

Does any Proposed Insured have any existing life insurance or annuities? Yes No

Is this application for insurance intended to replace any life insurance or annuities now in force? Yes No

Agent Replacement

Does any Proposed Insured have any existing life insurance or annuities? Yes No

Is this insurance intended to replace, in whole or part, any life insurance or annuities? Yes No

Special Requests/Remarks

Special Requests/Remarks:

Section expands when box is checked

Secondary Addressee

Electing Secondary Addressee

Secondary Addressee

Electing Secondary Addressee

First Name: Middle Name: Last Name: Suffix:

Street: Apt/Suite:

City: State: Zip Code:

Child Term Riders

Enter the required information.



Child Term Insurance Rider Form

Delete Child

First Name: Middle Name: Last Name: Suffix:

Date of Birth: Or Age: Gender:

Street: Apt/Suite: **Reuse Address**

City: State: Zip Code:

Phone Number: Phone Number Type:

Social Security No.:

Enter date of birth or age.

Tap or click to reuse an address

Select from list or enter new name

You must tap or click to save and proceed

Primary Beneficiaries for Child Insurance

+Add Primary Beneficiary

- Joelle Doe
- John Doe
- Owen Doe

+Add Contingent Beneficiary

Each child may have a different beneficiary.

Child Term Riders

Health questions apply to all proposed insured children.



Health History

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)? Yes No

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? Yes No

Has **any child proposed for insurance** ever been diagnosed or treated (including taking medication) by a member of the medical profession 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 No

Jasmine Doe - Child Insured
Jeremiah Doe - Child Insured

Identify the child for any "Yes" answer

"Yes" answer makes child ineligible. You may change the answer if it was selected by mistake.

Warning

Child is not eligible for coverage, please remove child from the application.

Delete Child

Edit Answer

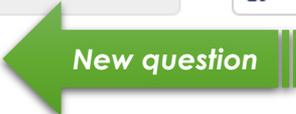
Tap or click to correct answer

Report of Licensed Agent



Report of Licensed Agent

Name of Licensed Agent	Agent Number	Account Number	% of Commission (Enter 100% if you are NOT splitting commission)
<input type="text" value="Arielle Agent"/>	<input type="text" value="123456"/>	<input type="text" value="29"/>	<input type="text"/>
Is the agent related to the Proposed Insured or Owner?			<input type="text" value="No"/>



Agent Address

Street	<input type="text" value="123 Main Street"/>		
City	State	Zip Code	
<input type="text" value="Asheville"/>	<input type="text" value="NC North Carolina"/>	<input type="text" value="12345"/>	
Agent Phone	Phone Number Type		
<input type="text" value="(555) 555-5555"/>	<input type="text" value="Work"/>		

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



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

Authorization & Acknowledgment



City	State
<input type="text"/>	<input type="text" value="NC North Carolina"/>

Summary of Coverage Applied For

Review the summary to confirm that the information is correct.



SafeShield (2020)

- ✓ Risk Qualifier
- ✓ Proposed Insured
- ✓ Beneficiaries
- ✓ Owner
- ✓ Payment Information
- ✓ Miscellaneous
- ✗ Children Proposed for Insurance
- ✓ Report of Licensed Agent
- ✓ eApp Review
- ✗ Finish
- ✓ **15 YT Non-ROP**

Premiums Details	
Monthly (EFT)	\$12.88
Quarterly	\$39.26
Semi-Annual	\$77.04
Annual	\$148.15

[Calculate](#) [Details](#)

Summary of Coverage Applied For

Proposed Insured :	Joelle Doe
Gender :	Female
Rate Class :	Tobacco
Plan :	15 YT Non-ROP
Policy Effective Date: :	12/06/2019
Policy Face Amount :	\$25,000
Billing Method :	Electronic Funds Transfer
Payment Frequency :	Monthly
Initial Premium Amount :	\$12.88
Subsequent Premium Payment :	\$12.88

[Previous](#) 9 of 10 [Next](#)

Any menu items not checked need attention. Click the link to return to the page.

Finish

eApp will let you know if any areas need attention before submitting.



Incomplete

The following warning or errors were found and require some attention.

Section	Field	Client	Error Message
Report of Licensed Agent	Street	eters	Street is required

Tap or click to complete

Finish

Application entries are complete. Please sign and submit the application by clicking the button below. 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 "Decline" button 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 signing your name with your finger, stylus, or mouse on the screen.

Please use your full name when entering the electronic signature.

PRINT Sign and Submit Sign and Get POS Decision

10 of 10 Next

Submit for underwriting review

Get Point of Sale underwriting decision

When complete, you can submit for underwriting review or request an immediate Point of Sale (POS) underwriting decision.

Electronic Signatures

Each party to the application must sign his or her own signature.



Finish

All required information has been entered. Your application is In Good Order.

Signature(s) are required from Joelle Doe. Please pass control to that person.

Name	Signee	Checklist	
Joelle Doe	Insured	x	<input type="button" value="Sign"/>
John Doe	Owner	x	<input type="button" value="Sign"/>
Ariel Agent	Licensed Agent	x	<input type="button" value="Sign"/>

Tap or click

Signature ceremony for Joelle Doe

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

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

You agree that by signing 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 signing your name with your finger, stylus, or mouse is your legal signature on this document.

Please use your full name when entering the electronic signature.

I agree

Occupation Graphic Design	Annual Income 100000	Household Annual Income 300000	
2. BENEFICIARY For multiple Primary or Contingent Beneficiaries, provide additional beneficiary information including % share in Section 8 Special Requests/ Remarks on Page 5			
PRIMARY BENEFICIARY First Name John	Middle Initial	Last Name Doe	Relationship to Proposed Insured Spouse
Date of Birth (MM/DD/YYYY)	Social Security No./Green Card No. 222-33-3444	Phone Number <input type="checkbox"/> Home <input type="checkbox"/> Work <input type="checkbox"/> Cell	

Must be checked

Toggle to collapse for reviewing document, then expand for consent.

Scroll through document.

Electronic Signatures

Scroll to the first "Sign" flag.



9. AUTHORIZATION & ACKNOWLEDGEMENT:

I authorize any licensed physician, medical practitioner, hospital, clinic, pharmacy benefit manager, other medical or medically related facility, insurance company, MIB, Inc., consumer reporting agency, or other organization, institution or person that has any records or knowledge of me or any proposed insured, to give any such information to Columbian Life Insurance Company ("the Company") or its reinsurers for underwriting or claims purposes. This authorization also includes information about drugs, alcoholism, prescription drug records, or any other medical history information. To facilitate rapid submission of such information, I authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the Company to collect and transmit such information. I understand my information may be subject to redisclosure to a third party and may no longer be protected by federal privacy laws. I authorize Columbian Life Insurance Company, or its reinsurers, to make a brief report of my personal health information to MIB. I understand a telephone interview may be necessary to verify or supplement information given to the Company on this application. This interview may be made from the Administrative Service Office or from a consumer-reporting agency by a trained interviewer acting on the Company's behalf. A photocopy of this form will be as valid as the original; this authorization will be valid for two (2) years from the date shown below, or the time limit permitted by applicable law in the state where the policy is delivered or issued for delivery. You may revoke this authorization by contacting us at PO Box 1381 Binghamton, NY 13902-1381 however, we retain the right to use any information obtained under your authorization prior to your revocation. I have read and understand the Conditions Relating to the Application and the Authorization & Acknowledgment. I acknowledge receipt and review of the Information Practices Relating to Underwriting Your Application. I have read and understand the fraud warning in Section 5 of this application.

I consent to the use of my electronic signature, and understand that my electronic signature is the legally binding equivalent to my handwritten signature. I will not, at any time in the future, repudiate the meaning of my electronic signature or claim that my electronic signature is not legally binding.

Tap or click

Sign

X

Electronic Signature of Proposed Insured

Have the client sign using fingertip, stylus or mouse

Enter signature

Joella Doe

Please sign within the border.

Clear Ok Close

Tap or click OK to continue

Continue applying the appropriate signature at each flag.

Be sure to submit

Enter signature

Please sign within the border.

Clear Use Previous Ok Close

Tap or click to apply previous signature

Finish

All eSignatures have been collected. **The application will not be submitted unless you select the Submit button**

PRINT Submit

Electronic Signatures



Click the  Home icon at the top right corner of the screen to return to your dashboard. The application will show in your Portfolio.

You may also search for a case or begin a new case from your dashboard.





eApp Support

Please contact Sales Support at 800-423-9765, ext. *7582 if you need assistance.

Columbian Life Insurance Company

Home Office: Chicago, IL

Administrative Service Office: Binghamton, NY 13902

For agent use only. Not for use with consumers.

For complete terms, please refer to Policy/Rider Form Nos. 1H841-CL, 1H885-CL, 1F604-CL, 1F605-CL, 1H906-CL, 1H907-CL, 1H908-CL, 1H915-CL, 1H916-CL, 1H931-CL, 1H932-CL, 1H933-CL and 1H934-CL or state variation. Product/Rider specifications and availability may vary by state.