



**Dignified Choice<sup>®</sup>**  
**Final Expense**  
*Electronic Application*




## 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***
- ***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

*New!*



## 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. 5354CFG followed by your state abbreviation.

# Completing a New eApp



**Log in to the Partners Website**

**Select Resources / eApp (new product)**

**Select New eApp**

**Select State**

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

**Select Product**

**Create**

# Risk Qualifier



## Final Expense (2020)

- Risk Qualifier
- Proposed Insured
- Beneficiaries
- Owner
- Payment Information
- Miscellaneous
- Report of Licensed Agent
- eApp Review
- Finish
- Classic Elite**
- Classic Select**
- Classic Advantage**

Premiums Details

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

## Risk Qualifier

Height (Ft) 
 Height (In) 
 Weight (lbs)

Date of Birth 
 Age

**Required information in yellow**

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?  Yes  No

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?  Yes  No

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 received a kidney transplant, or ever received a kidney transplant within the last twelve (12) months, received kidney  Yes  No

Have you ever had a surgical operation, a diagnostic test (except for HIV) other than for routine screening, that has not been completed?  Yes  No

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?  Yes  No

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)?  Yes  No

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)?  Yes  No

**Color indicates eligibility**



# Risk Qualifier

Interactive Risk Qualifier asks knockout questions first.

Answers generate warnings as needed.

**Final Expense (2020)**

**Risk Qualifier**

Height (Ft) 5 Height (In) 3 Weight (lbs) 120

Date of Birth 08/11/1962 Age 57

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?

**Warning**

Client does not meet eligibility requirements.

Return to Product Page Edit Answer

Locks application from editing

Tap or click to correct answer

Knockout question

Choose “Edit Answer” if button was selected by mistake.

The “Return to Product Page” button will lock the application from editing.



# Risk Qualifier

A warning will appear if answer changes plan eligibility.



The screenshot shows a warning dialog box with a blue header "Warning" and a white body containing the text "Client's answer makes a plan unavailable." Below the text are two buttons: "Continue" and "Exit". A yellow callout bubble points to the "Continue" button with the text "Tap or click to continue with Risk Qualifier". Another yellow callout bubble points to the "Exit" button with the text "Locks application from editing". In the background, a list of plan options is visible: "Classic Elite" (disabled), "Classic Select" (disabled), and "Classic Advantage" (selected). A yellow callout bubble points to the "Classic Advantage" option with the text "Click for details.". To the right, a radio button is selected, and a yellow callout bubble points to it with the text "Ineligible for Full Benefit plans".

The screenshot shows an "Underwriting Details" dialog box with a blue header and a white body. The text inside reads: "Client does not meet eligibility requirements due to the answer provided." Below this is a bulleted list: "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 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)?". At the bottom right is an "OK" button.



# Premiums

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

I have never visited a physician or a medical facility

Date of Last Visit

Name of Physician or Medical Facility  Address of Physician or Medical Facility

Reason Consulted  Treatment / Diagnosis

Have you used any form of tobacco or nicotine products including cigarettes, cigars, pipes, e-cigarettes, chewing tobacco, snuff, nicotine patches, or nicotine gum in the past twelve (12) months?  Yes  No

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

Gender:  Plan of Insurance:  Amount of Insurance (Face Amount):

Automatic Premium Loan:  Yes  No

Accidental Death Benefit

Children's Term Insurance Rider Number of children:  Number of units:

Accelerated Death Benefit

Tap or click to calculate premiums

Tap or click to continue

Premium Details				
Classic Elite	Monthly (EFT)	Quarterly	Semi-Annual	Annual
Base Policy	\$75.06	\$225.18	\$450.36	\$900.72
Accidental Death Benefit	\$2.72	\$8.16	\$16.32	\$32.64
Children's Term Insurance Rider	\$1.57	\$4.71	\$9.42	\$18.84
Accelerated Death Benefit - Terminal Illness	No charge	No charge	No charge	No charge

Base policy and rider premiums shown separately

# Proposed Insured

Complete required fields.



**Risk Qualifier Status**

Based on the information entered, this client may be eligible for a Final Expense 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

**Proposed Insured Information**

First Name  Middle Name  Last Name

Gender  Date of Birth  Age

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

**Contact Information**

Phone Number  Phone Number Type  eMail

Street  Apt/Suite

City  State  Zip Code

2 of 10

*Carried forward from the calculator.*

*To change, return to the calculator*



# 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  
Reuse Address

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. If "Other" is chosen, additional fields will appear.

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 Social Security No. Green Card

Select Or

Contact Information

Street Apt/Suite Reuse Address

City State Zip Code

Select

*Expands if "Other" is selected*



# 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 “Draft initial premium from the account below at a future date.”

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

When a future effective date is selected, the Immediate Draft option is disabled.

Payment Frequency

Effective Date *Future date*  
12/22/2019

Payment Frequency  
Monthly

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.

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 application.

Initial Premium *Disabled*

Modal Premium  
\$81.63

# Payment Options - Immediate Draft



To have the initial premium drafted on receipt of the application, leave the Effective Date as today's date and select Immediate Draft.

The premium may be drafted the same day the application is submitted.

Payment Frequency

Effective Date *Leave at today's date*

11/18/2019

Payment Frequency *Disabled*

Monthly

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.

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 application.

Initial Premium

Modal Premium

\$81.63



# Payment Options - Backdating

Policy may be backdated up to six months to save age.

To backdate, change the Effective Date to the desired date.

Back premiums to the Effective Date will be required.

Future draft date is not available when backdating.

Payment Frequency

Effective Date *Enter the desired date*  
08/18/2019

Payment Frequency *Disabled for backdating*  
Monthly

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.

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 application.

Initial Premium

Modal Premium \$81.63

Initial Premium Amount

*eApp will calculate back premium*

The suggested Initial Premium Amount for a back dated policy is \$244.89. This will pay the policy to 12/18/2019.





# Subsequent Premium Payments

For EFT payments, choose a day between the 1<sup>st</sup> and the 28<sup>th</sup> 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: 2nd Week    Select Day: Friday    Beginning in the month of: December

Bank Account Authorization

Transit / Routing Number (must have 9 digits): 021300077    Financial Institution: KEY BANK

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 feature!*

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 delivery preference, answer 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*

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

*"Yes" answers will trigger any necessary additional questions*

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

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

First Name  Last Name  Suffix

Date of Birth  Gender

Street  Apt/Suite

City  State  Zip Code

Phone Number  Phone Number Type

Social Security No.

Primary Beneficiaries for Child Insured #1

*If birth date is unknown, subtract age from effective date.*

*Tap or click to reuse an address*

*Select from list or enter new name*

*You must tap or click to save and proceed*

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)

Is the agent related to the Proposed Insured or Owner?

Agent Address

Street

City

State

Zip Code

Agent Phone

Phone Number Type

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

'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.

Authorization & Acknowledgement

City

State

**New question**

**Required**

**You must provide paper copies of required disclosures.**

**Required**

# Summary of Coverage Applied For



Review the summary to confirm that the information is correct.

- Check the first box if the client will accept a plan other than the one applied for.
- Check the second box if the face amount should be adjusted to match the premium amount if the policy issued is other than the one applied for.

### Final Expense (2020)

- ✓ Risk Qualifier
- ✓ Proposed Insured
- ✓ Beneficiaries
- ✓ Owner
- ✓ Payment Information
- ✓ Miscellaneous
- ✓ Children Proposed for Insurance
- ✓ Report of Licensed Agent
- ✓ eApp Review
- ✓ Finish
- ✓ Classic Elite
- ✓ Classic Select
- ✓ Classic Advantage

Monthly (EFT)	\$81.10
Quarterly	\$247.04
Semi-Annual	\$484.76
Annual	\$932.23

Calculate Details

### Summary of Coverage Applied For

Proposed Insured : Jane Doe  
Gender : Female  
Plan : Classic Elite  
Policy Effective Date : 11/18/2019  
Policy Face Amount : \$25,000  
Billing Method : Electronic Funds Transfer  
Payment Frequency : Monthly  
Initial Premium Amount : \$81.10  
Subsequent Premium Payment : \$81.10

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) years, a face amount less than indicated on this application and riders may not be available.

Adjust the face amount to match premium?

9 of 10 Next

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



# Finish

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

Incomplete

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

Section	Field	Message
Report of Licensed Agent	Is the agent related to the Proposed Insured or Owner?	is required

*Tap or click to complete*

When the application is complete, you may:

- Submit for underwriting review *or*
- Request an immediate Point of Sale (POS) underwriting decision.

Final Expense (2020)

- ✓ Risk Qualifier
- ✓ Proposed Insured
- ✓ Beneficiaries
- ✓ Owner
- ✓ Payment Information
- ✓ Miscellaneous
- ✓ Children Proposed for Insurance
- ✓ Report of Licensed Agent
- ✓ eApp Review

**Finish**

- ✓ Classic Elite
- ✓ Classic Select
- ✓ Classic Advantage

Premiums Details

Monthly (EFT)	\$81.10
Quarterly	\$247.04
Semi-Annual	\$484.76
Annual	\$932.23

Calculate Details

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.

PRINT Sign and Submit POS Authorization

Previous 10 of 10 Next

*Submit for underwriting review*

*Get Point of Sale underwriting decision*

*Motor Vehicle Report is not immediately returned for CA, HI, KS or MO.*

*POS underwriting decision cannot be rendered for applicants age 18-35 in those states.*

# Submitting for POS Decision



Applicant and Agent must sign Authorization and Acknowledgement.

Finish

All required information has been entered. Your application is In Good Order.  
Signature(s) are required from Jane Doe. Please pass control to that person.

Name	Signee	Checklist	
Jane Doe	Insured	x	<input type="button" value="Sign"/>
	Licensed Agent	x	<input type="button" value="Sign"/>

Tap or click

Signature ceremony for John 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 front-facing camera will create a legal signature on this document.

I agree

Product: Final Expense

Proposed Insured: John Doe  
Please Print Name

Policyowner (if other than Proposed Insured): John Doe  
Please Print Name

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/Columbian Mutual 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/Columbian

Person signing must agree and confirm

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

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

X  11/20/2019

Signature of Proposed Insured Date

Tap or click to apply signature

Enter signature

John Doe

Please sign within the border.

Tap or click to apply signature



# Getting POS Decision

Decision will be delivered in less than two minutes.




Finish

---


Please wait while your POS decision is processed...

Previous 9 of 9 Next

 Loading...

Finish

---

**Client Name:** John Doe  
**Plan:** Classic Elite  
**Status:**  Approved!

The policy will be issued as applied for. Please be sure to tap or click the Submit button or the application will be considered withdrawn. Thank you for your business.

*Coverage amount may be reduced if the Insured has existing coverage with Columbian.*

[Sign and Submit](#)

*Be sure to sign and submit the application.*



# Electronic Signatures

Each party to the application must apply his/her own signature.

**Finish**

All required information has been entered. Your application is In Good Order.  
Signature(s) are required from Jane Doe. Please pass control to that person.

Name	Signee	Checklist	
Jane Doe	Insured	x	<b>Sign</b>
	Licensed Agent	x	<b>Sign</b>

**Cancel Signing**

*Tap or click*

The Applicant must review the entire document before signing.

**Signature ceremony for Jane 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.

I agree

**Confirm**

---

Home Address/Apt. #, Street  
53 Lanning Ave

City  
Asheville

State  
NC

Zip Code  
28806-4416

Email

Answer only for ages 18-35: Do you have a Driver's License?  YES  NO  
If YES, please provide your Driver's License No. and State.  
If NO, please provide details in Section 7 Special Requests / Remarks on Page 3.

Driver's License No.

State

WEIGHT 119 lbs.

HEIGHT 5 Ft. 3 In.

**2. BENEFICIARY** For multiple Primary or Contingent Beneficiaries, provide additional beneficiary information including % share in Section 7 Special Requests/ Remarks on Page 3.

PRIMARY BENEFICIARY First Name	Middle Initial	Last Name	Relationship to Proposed Insured
John		Doe	Spouse

*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 10 of this application.

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

2/19/11/2      X Sign      2/19/11/2  
Date of Application      Electronic Signature of Proposed Insured      (Date)

Tap or click

Enter signature

Jane Doe

Please sign within the border.

Clear      OK      Close

Have the client sign using fingertip, stylus or mouse

Tap or click OK to continue

Continue applying the appropriate signature at each flag.

Enter signature

Use Previous

Please sign within the border.


Clear      Use Previous      OK      Close



Tap or click to apply previous signature

# Submit for Underwriting Review



When all signatures are complete, click or tap the Finish button.

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

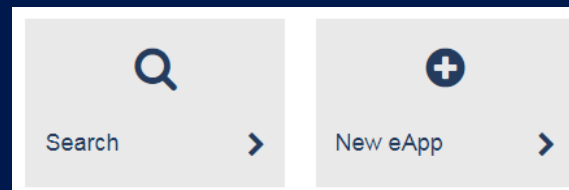
Recent Portfolios				
	Product	First Name	Last Name	
Portfolio name: JDoe6E6626 - Last Saved: 11/21/2019				
EApp #23360	Final Expense	Janet	Doe	Incomplete
Portfolio name: JDoe6DE186 - Last Saved: 11/21/2019				
EApp #2050015672	Final Expense	John	Doe	
Portfolio name: JDoe6DDE08 - Last Saved: 11/20/2019				
EApp #2050015650	Final Expense (2020)	Jane	Doe	Submitted 

*POS complete but app not submitted. App will be withdrawn if not submitted in 10 days.*

*Hover for status*

*Tap or click to download PDF file*

You may also search for a case or begin a new eApp from the home page.





# eApp Support

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

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.

For agent use only. Not for use with consumers.

Refers to Policy/Rider Forms 1F607, 1F607-CL, 1F608-CL, 1F609, 1F609-CL, 1H884, 1H884-CL, 1H885, 1H885-CL, 1H915, 1H915-CL, 1H916 and 1H916-CL or state variation. Product specifications and availability may vary by state.

Product/Rider specifications and availability may vary by state.