COLUMBIAN LIFE INSURANCE COMPANY
HOME OFFICE: CHICAGO, IL
ADMINISTRATIVE SERVICE OFFICE: [VESTAL PARKWAY EAST
PO BOX 1381, BINGHAMTON, NY 13902-1381
TELEPHONE: (607) 724-2472 / FAX: (866) 253-9459 / www.cfglife.com]

STATEMENTS MADE TO THE MEDICAL EXAMINER

1. PROPOSED INSURED: First Name	Middle Initial	Last Name
2. Height / Weight	Have you lost weight in the past year? ☐ Yes ☐ No If "Yes", how much? _____lbs. Cause?	

3. **FAMILY INFORMATION OF PROPOSED INSURED**	**Age, If Living**	**If Deceased, Age at Death**	**Cause of Death**
Father:			
Mother:			
Brothers & Sisters: No. Living _____ No. Dead _____			

4. HEALTH HISTORY:

Any person who knowingly presents a false statement in an application for life insurance may be guilty of a criminal offense and subject to penalties under state law.

Part 1

1. In the past ten (10) years, have you been diagnosed or treated by a member of the medical profession for heart disease, enlarged heart, irregular heartbeat, stroke, TIA (mini stroke), chest pain, emphysema, chronic respiratory disorder, lung disorder, liver disease including hepatitis, tumor or cancer, kidney disease, connective tissue disease, systemic lupus, circulatory or neurological disease or disorder, psychiatric disorder, depression or mental incapacity?..... ☐ Yes ☐ No
2. In the past ten (10) years, have you been diagnosed or treated by a member of the medical profession for drug or alcohol abuse or dependency including prescription drugs, or have you used any illegal drugs in any form?..... ☐ Yes ☐ No
3. In the past ten (10) years, have you 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 tested positive for Human Immunodeficiency Virus (HIV)?..... ☐ Yes ☐ No

Part 2

1. In the past five (5) years, have you been diagnosed or treated by a member of the medical profession for anemia, or any disorder of the blood or blood vessels, arthritis, or disorder of the bones or muscles, digestive or intestinal disorder or bleeding, high blood pressure, diabetes, seizure disorder, or asthma?..... ☐ Yes ☐ No
2. In the past five (5) years, have you been hospitalized consulted a physician or medical facility for any reason or been advised to have any diagnostic test, hospitalization or surgery, which has not been completed or are you still awaiting a diagnosis or test result from your physician or medical facility?..... ☐ Yes ☐ No

Part 3

1. Have you experienced any unexplained weight loss of more than ten (10) pounds in the last year?.... ☐ Yes ☐ No
2. Have you applied for life, disability or health insurance, which was declined, postponed, rated or modified?..... ☐ Yes ☐ No
3. In the past five (5) years, have you ever been prescribed medication, or taken any medication prescribed by a physician, or been hospitalized or consulted a physician or medical facility for any reason? ..... ☐ Yes ☐ No
4. 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 In the past thirteen (13) to thirty-six (36) months? ☐ YES ☐ NO

PLEASE PROVIDE DETAILS OF ALL "YES" ANSWERS IN THE AREA BELOW.
(Attach a separate sheet if more space is needed.)

QUESTION	TREATMENT/DIAGNOSIS	DATES AND DURATION	NAME, ADDRESS, AND TELEPHONE NUMBER OF PHYSICIAN, MEDICAL FACILITY

AUTHORIZATION & ACKNOWLEDGMENT:

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 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 declare and represent that the foregoing statements and answers have been correctly recorded and that they are full, complete and true to the best of my knowledge and belief and shall constitute a part of the application. **I have read and understand the fraud warning in Section 4 of this application.**

_____ **X** _____

Date Proposed Insured

X _____

Witness

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MEDICAL EXAMINER'S CONFIDENTIAL REPORT

TO BE COMPLETED IN PRIVATE AND MAILED DIRECTLY TO THE COMPANY INSTRUCTED ON FEE VOUCHER.

1. PROPOSED INSURED: First Name	Middle Initial	Last Name
2. Height / 3. Weight	4. Did you Measure Height? ☐ Yes ☐ No Did You Weigh? ☐ Yes ☐ No	

5. Blood Pressure (Record All Readings)	At Rest	After Exercise (20 Body Bends)	3 Minutes Later
Systolic 4th Phase			
Diastolic 5th Phase			
Pulse Rate			
Irregularities (No. per min.)			

6. (a) In your opinion, is there anything about his or her habits, mode of life or character, which might adversely affect insurability? ☐ Yes ☐ No

(b) Is there any reason why you cannot unqualifiedly recommend Proposed Insured as an insurance risk? ☐ Yes ☐ No

(c) Are you related to the Proposed Insured or Licensed Agent? (If "Yes", explain.) ☐ Yes ☐ No

(d) How well do you know Proposed Insured?

7. Urinalysis: **PLEASE MAIL A SPECIMEN OF URINE TO LABORATORY**
(a) Are you satisfied that the specimen is authentic? ☐ Yes ☐ No

Specific Gravity	Reaction	Albumin	Sugar

PLEASE PROVIDE DETAILS OF ADVERSE FINDINGS AND OPINIONS BELOW
(Attach a separate sheet if more space is needed.)

Examined at: ☐ My Office
☐ Proposed Insured's Residence
☐ Proposed Insured's Place of Business

Examiner's Name: _____
Address: _____
City, State & Zip: _____

Date: _____ Time: _____ AM / PM

X _____
Examiner

FEE VOUCHER

DO NOT DETACH - MAIL ENTIRE FORM DIRECTLY TO COLUMBIAN LIFE INSURANCE COMPANY IN THE ENVELOPE PROVIDED BY THE AGENT REQUESTING THE EXAM.

TO THE MEDICAL EXAMINER: This voucher will serve as your bill to Columbian Life Insurance Company. Payment will be rendered for reasonable and customary fees upon receipt by the Company. **Please print or type all information.**

1. Proposed Insured's Full Name:	6. Name of Examiner:
2. Date of Examination	7. Paramedical Company You Represent:
3. Agent Requesting Examination	8. Address:
4. Are you an appointed Columbian Life medical examiner? ☐ Yes ☐ No If "No", please give your license number:	9. City, State, & Zip:
5. Exam Fee $ _____ HOS Collection $ _____ EKG-Resting $ _____ Other: _____ $ _____ Blood + HOS Collection $ _____ **TOTAL FEE(s):** $ _____	10. Taxpayer Identification No. (TIN):

THIS SECTION TO BE COMPLETED ONLY IF EXAM IS PERFORMED BY A MEDICAL DOCTOR

1. (a) Do you find any evidence of past or present disease of:

(1) Brain or nervous system? (test pupillary and patellar reflexes for Romberg's sign, tremors, etc.)	☐ Yes ☐ No
(2) Ears, eyes, nose, or throat?	☐ Yes ☐ No
(3) Thyroid or other glands?	☐ Yes ☐ No
(4) Lungs or other respiratory organs?	☐ Yes ☐ No
(5) Heart or blood vessels?	☐ Yes ☐ No
(6) Any arteriosclerosis? (If present or suspected, please examine eye grounds and reports findings)	☐ Yes ☐ No
(7) Stomach or other abdominal organs? (any scars, tenderness, masses, rigidity, etc.)	☐ Yes ☐ No
(8) Genito-urinary system?	☐ Yes ☐ No
(9) Bones, joints or skin?	☐ Yes ☐ No

(b) Does he/she have:

(1) A hernia?	☐ Yes ☐ No
(2) Evidence of varicose veins or ulcers?	☐ Yes ☐ No
(3) Deformity, loss of limbs or lameness?	☐ Yes ☐ No
(4) Unhealthy, frail or anemic appearance?	☐ Yes ☐ No
(5) Appearance older than age stated?	☐ Yes ☐ No

2. Is there any history of rheumatic fever, chorea, scarlet fever, diphtheria, recurrent tonsillitis, or syphilis? ☐ Yes ☐ No

3. (a) is there a murmur? ☐ Yes ☐ No

TIMING	INTENSITY	QUALITY
☐ Systolic	☐ Faint (Gr 1-2)	☐ Soft
☐ Presystolic	☐ Mod (Gr 3-4)	☐ Blowing
☐ Diastolic	☐ Loud (Gr 5-6)	☐ Rough

(b) Is murmur transmitted? (If "Yes", where?) ☐ Yes ☐ No

(c) Is the murmur constant or inconstant? ☐ Constant ☐ Inconstant

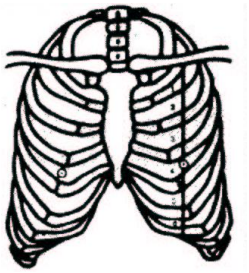
(d) On exercise, does the murmur
☐ Intensify? ☐ Disappear? ☐ Decrease? ☐ Remain unchanged?

(e) Show location of murmur:

Apex is located in the _____ intercostal space _____ inches to left of the midsternal line as indicated by **X**

Area over which murmur is heard by ☐

Direction of transmission by ⟶



(f) What is your impression of the murmur?

(g) Hypertrophy? (Examine heart in erect and recumbent position.)
☐ None ☐ Slight ☐ Moderate ☐ Marked

PLEASE PROVIDE DETAILS OF ADVERSE FINDINGS AND OPINIONS BELOW:
(Attach a separate sheet if more space is needed.)

Examined at: ☐ My Office
☐ Proposed Insured's Residence
☐ Proposed Insured's Place of Business

Examiner's Name: _____
Address: _____
City, State & Zip: _____

Date: _____ Time: _____ AM / PM

X _____ M.D.
Examiner