Application to: Colonial Life & Accident Insurance Company PO Box 1365 Columbia, SC 29202

Proposed Insured Section					
Proposed Insured's Name (First, MI, Last)		Employee ☐ Spouse ☐ Dependent ☐	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Social Security No.
Home Address – Street (No PO Box)	City	State	Zip Code		Home Phone No. Business Phone No.
Date Employed	Occupation/Job Title	Hrs. Worked/Week	Annual Base Salary		State of Birth
Owner if Other than Proposed Insured (Name and Address)					Social Security No.
Contingent Owner (if applicable) (Name and Address)					Social Security No.

Employee Section (Complete only if proposed insured is not the employee)					
Employee Name (First, MI, Last)	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Relationship to Proposed Insured	Social Security No.	Date Employed

Billing Section				
Payroll Deduction Employer Name	Employer Address (Street-City-State-Zip)	Employee ID / Payroll No.	Employee Class	Section/ Dept. No.

Beneficiary Section					
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)	Primary ☐ Contingent ☐	Age	Benefit %	Relationship to Proposed Insured	Social Security No.

Spouse and/or Dependent Child Rider Section				
Name (First, MI, Last)	Gender	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
	M ☐ F ☐			
	M ☐ F ☐			
	M ☐ F ☐			
	M ☐ F ☐			
	M ☐ F ☐			
	M ☐ F ☐			

Eligibility Questions	Proposed Insured	Your Spouse
1. Within the past 12 months, have you, or your spouse if applying for spouse coverage, used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery system?	Yes ☐ No ☐	Yes ☐ No ☐
2. Is the Proposed Insured actively working? 2.a. If "No", is the Proposed Insured disabled or unable to work?	Yes ☐ No ☐ Yes ☐ No ☐	
3. Is your spouse disabled or unable to work?		Yes ☐ No ☐

Plan Section			
Policy Plan Code	Face Amount $	Target Premium (UL only) $	Monthly Premium $

Complete for any riders				
Rider Plan Code	Units/Face Amount	Monthly Premium	Life Options	
			Option ☐ A ☐ B (UL only)	
			Automatic Premium Loan if available? Yes ☐ No ☐	Planned Premium $_____
			Settlement Option	Rider Premium $_____
Total Monthly Premium $				
Method of Payment (if other than payroll deducted) ☐ Bank Draft ☐ Annual ☐ Semi-Annual ☐ Quarterly				

Life Adjustment

☐ Existing Policy Number _____ ☐ Increase ☐ Rider Addition ☐ Tobacco to Non-tobacco Policy ☐ Exercising Guaranteed Purchase Option ☐ Option Change (UL only) ☐ Term Life Conversion ☐ Rider Conversion

For rider additions, option changes, a change in smoker status, or UL increases, if the Beneficiary Section of this application is completed, this designation *replaces* any other Beneficiary Designation on file for this Policy.

Replacement Section

4. Does the Proposed Insured have any existing life coverage? If yes, answer question 5; answer 6 only if applying for Universal Life.	Yes ☐ No ☐
5. Will any life insurance or annuities with this or any other company be modified or discontinued if the coverage applied for is issued? If yes, provide details and complete form if applicable.	Yes ☐ No ☐

Insured's Name	Insurance Company	Amount of Coverage

6. Is the Proposed Insured using funds from an existing policy(s) or contract(s) to fund the new policy (1035 Exchange)? If yes, complete the 1035 Exchange form.	Yes ☐ No ☐

AIDS Section	Proposed Insured	Your Spouse	Your Dependent
7. Have you, your spouse or your dependent if applying for coverage, tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or received medical advice or sought treatment for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Height and Weight Section – Required for all face amounts

Indicate Your Current: Height_____ Weight_____

Indicate Your Spouse's Current: Height_____ Weight_____

Simplified Issue	Proposed Insured	Your Spouse
8. Within the past 24 months, have you, or your spouse if applying for spouse coverage, used marijuana, cocaine, heroin or any other illicit drug or controlled substance, with the exception of those prescribed for you by a physician; received medical advice or sought treatment for drug and/or alcohol abuse; or been advised by a doctor to reduce your consumption of drugs or alcohol?	Yes ☐ No ☐	Yes ☐ No ☐
9. Within the past 24 months, have you, or your spouse if applying for spouse coverage, been charged with operating a motor vehicle under the influence of drugs and/or alcohol; or pled guilty to, pled no contest to, or been convicted of or have a charge pending for any felony or misdemeanor?	Yes ☐ No ☐	Yes ☐ No ☐
10. Within the past 24 months, have you, or your spouse if applying for spouse coverage, been prescribed 3 or more medications (including diuretic) to be taken concurrently for high blood pressure; or been prescribed medication for elevated cholesterol and high blood pressure?	Yes ☐ No ☐	Yes ☐ No ☐
11. Within the past 10 years, have you, or your spouse if applying for spouse coverage, received medical advice or sought treatment for internal cancer, including leukemia or melanoma of Clark's level III or higher?	Yes ☐ No ☐	Yes ☐ No ☐
12. Have you, or your spouse if applying for spouse coverage, ever received medical advice or sought treatment (including medication) for: Heart Attack (MI)/Angina; Cardiac/Circulatory Surgery; Peripheral Vascular Disease; Stroke; Chronic Kidney (renal) Failure; Systemic Lupus (SLE) Disease; Congestive Heart Failure/Cardiomyopathy; Emphysema; Manic Depressive Disorder (Bipolar); Insulin Dependent Diabetes; Diabetes Diagnosed Prior to Age 40; Chronic Obstructive Pulmonary Disease (COPD); Schizophrenia; Multiple Sclerosis; Paralysis; Chronic Hepatitis; Hepatitis (except A)	Yes ☐ No ☐	Yes ☐ No ☐

Complete height/ weight and question 13 for ages 0 – 14 for juvenile Universal Life Complete height/weight and questions 13 - 15 for ages 15 – 17 for juvenile Universal Life Indicate Your Dependent 's current: Height _____ Weight _____	Your Dependent
13. Has your dependent child ever received medical advice or sought treatment for cystic fibrosis, diabetes, heart disorder, leukemia, cancer (other than skin cancer), or seizures; or been hospitalized for any respiratory disorder including asthma?	Yes ☐ No ☐
14. Within the past 24 months, has your dependent child used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, with the exception of those prescribed for the dependent child by a physician; or received medical advice or sought treatment for drug and/or alcohol abuse?	Yes ☐ No ☐
15. Within the past 24 months, has your dependent child been charged with operating a motor vehicle under the influence of drugs and/or alcohol; or pled guilty to, pled no contest to, or been convicted of or have a charge pending for any felony or misdemeanor?	Yes ☐ No ☐

Full Underwriting	Proposed Insured
16. Within the past 24 months, have you engaged in hang gliding, mountain climbing, flying ultralights, parachuting, sky diving, ballooning, or scuba diving to depths of more than 75 feet? If yes, provide details in the Additional Data Section.	Yes ☐ No ☐
17. Within the past 24 months, have you flown as a student or private pilot; engaged in auto, motorcycle, or boat racing; or participated in any similar sport or avocation? If yes, provide: Type of avocation _____ and complete avocation questionnaire.	Yes ☐ No ☐
18. Within the past 5 years, have you had your driver's license revoked or suspended, been charged with operating a motor vehicle under the influence of drugs and/or alcohol; or pled guilty to, pled no contest to, have a charge pending or been convicted of 3 or more speeding or other moving violations? If yes, provide: Type of violation and date _____	Yes ☐ No ☐
_____ Driver's license number _____ State of issue _____	
19. Have you ever used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, with the exception of those prescribed for you by a physician; received medical advice or sought treatment for drug and/or alcohol abuse; or been advised by a doctor to reduce your consumption of drugs or alcohol? If yes, provide:_____	Yes ☐ No ☐
Type of treatment: _____ Name of facility: _____ Address of facility:_____ Type of abuse: Alcohol _____ Drug _____Type of drug _____ Frequency of use: _____ Date last used:_____ Are you an active member in Alcoholics Anonymous (AA) or any similar support group? Yes ☐ No ☐ If yes, list type of group _____	
20. Have you ever pled guilty to, pled no contest to, have a charge pending or been convicted of a felony or misdemeanor? If yes, provide: Reason(s) _____	Yes ☐ No ☐
_____ Date (s)_____ Are you currently on probation?	Yes ☐ No ☐
21. Have you ever received medical advice or sought treatment (including medication) for any condition listed below? If yes, provide details in the Health Details Section. Cancer or Tumor including leukemia or melanoma; Circulatory, Heart, Blood Vessel Disease or Disorder; Heart Murmur; Blood Disease or Lymph Node Disorder; Heart Attack (MI); Chest Pain / Angina; High Blood Pressure; Stroke; Paralysis; Epilepsy; Thyroid Disorder; Diabetes; Asthma, Emphysema, Lung or Respiratory Disorder; Liver Disease or Disorder; Gastrointestinal or Digestive Disease or Disorder; Kidney or Genitourinary Disease or Disorder; Nervous or Mental Disorder; Skin, Bone, Muscle or Joint Disorder	Yes ☐ No ☐
22. Within the past 5 years, have you been confined to a hospital or medical facility, seen a doctor for any reason other than stated on this application, or are you currently taking medication or receiving medical advice? If yes, provide details in the Health Details Section.	Yes ☐ No ☐
23. Do you have any plans for foreign travel? If yes, provide details in the Additional Data Section.	Yes ☐ No ☐

24. Complete for family history:

	Age if Living	Age at Death	List Health Conditions and, if Deceased, Cause of Death
Father			
Mother			
List Siblings	Age if Living	Age at Death	List Health Conditions and, if Deceased, Cause of Death

Health Details Section

For yes answers, provide details below.

Condition Name / Medication Name & Dosage	Diagnosis Date and Duration	Doctor/ Hospital Name, Address & Phone #	Date of Treatment	Type of Treatment Received

Additional Data Section

Agreement Section

THE PROPOSED INSURED AGREES AS FOLLOWS:
Any person who knowingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison. The answers and statements above are true and complete. Except as otherwise provided in the Conditional Receipt bearing the same date as this application (if any),I understand that this application will not be binding upon Colonial Life & Accident Insurance Company (Colonial) until both: 1) the policy is issued; and 2) the first premium is paid. Items 1 and 2 must occur while any conditions affecting insurability are the same as described above. I understand that any untrue statement or material misrepresentation may result in claim denial or rescission of coverage. If coverage is rescinded, Colonial's only obligation will be to refund all premiums paid. I certify under penalties of perjury that the Social Security number shown on this form is my correct TAXPAYER IDENTIFICATION NUMBER.
If applicable, I have received and read a copy of the Notice of Insurance Information Practices (which includes MIB, Inc. Disclosure Notice). I hereby authorize Colonial Life & Accident Insurance Company to release information to the MIB.
I acknowledge that ☐ I have ☐ I have not received a full ledger illustration according to the NAIC regulations and I understand that an illustration conforming to the policy as issued (if applicable) will be provided at the time of policy delivery.
I have paid to the agent named in this application $_____ for the first premium due on this policy. This amount is to be applied in accordance with the provisions of the application and the receipt.
I elect to be interviewed if any investigative consumer report is prepared in connection with this application. Yes ☐ No ☐

Signed at: (City)_____ (State) _____ (Date) _____
mm/dd/yyyy

(x)_____ (x)_____
Signature of Proposed Insured Signature of Owner (if Other than Proposed Insured)

Agent Section

Agent's Name (If Present)_____
Please Print

Do you have knowledge or reason to believe that the Proposed Insured is intending to replace any existing insurance? Yes ☐ No ☐

I have explained to the Proposed Insured all exceptions and limitations pertaining to the coverage(s) applied for. I hereby certify that I know nothing affecting the insurability of the Proposed Insured, which is not fully set forth in this application. I have not made, nor agreed to make, any rebate of premium for insurance. I further certify that I am a licensed agent in the state where this application is being taken. I certify that ☐ I have ☐ I have not used a full ledger illustration according to the NAIC regulations and I understand that an illustration conforming to the policy as issued (if applicable) will be provided at the time of delivery.

Date_____ (x)_____ License No._____ Code No._____
mm/dd/yyyy Signature of Licensed Agent