

Thank you for your interest in applying for the Columbian Mutual Medicare Supplement plan!

This application needs to be reviewed and signed by an Agent before it can be submitted to Columbian Mutual. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: dann@lowinsure.com
- Mail: CDA Insurance LLC
2160 W 11th Ave
Eugene, Oregon 97402

| |
|--|
| Other Important Information |
| Download Medicare's Choosing a Medigap Policy Guide (.pdf) |
| Download Policy Outline (.pdf) |

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.



**COLUMBIAN MUTUAL
LIFE INSURANCE COMPANY**

Home Office: Binghamton, NY 13902
Administrative Service Office: P.O. Box 2620
Omaha, NE 68103-2620

**Application Submission Checklist To Columbian Mutual Life For Medicare
Supplement Coverage – OREGON**

**THIS APPLICATION MUST BE USED TO WRITE COLUMBIAN MUTUAL LIFE MEDICARE
SUPPLEMENT PRODUCTS**

- Application**
 1. Complete "Plan Information" Box.
 2. Refer to the Outline of Coverage for policy forms.
 3. Answer all questions in full.
 4. Sign and Date in all places indicated.
 5. Be sure to leave all applicable forms with the proposed insured.
 6. See reverse side of this page for additional detailed information.
- Collect Premium Amount**
 - The full modal premium is collected at the time of application.
 - Follow instructions on page 1 of **Calculate Your Premium form (T05_422)** to calculate the premium. Complete the form and return with the application.
 - Calculate the premium based on age at the time of application.
 - There is a one-time application fee of \$25.00 (per applicant) that will be collected with the initial payment.
- Provide Client with Buyer's Guide**
- Provide Client with Outline of Coverage**
- Complete Producer Information page**
- If applicable, complete the Authorization for Electronic Funds Transfer form (ACH/BSP form T05_420) and return with the completed application**
- Provide Client with Conditional Receipt signed by agent (if applicable), and provide Client with Notice of Information Practices**
- Complete, sign and provide client with copy of the Authorization To Disclose Personal Information (HIPAA form T05_419_0710). This form is NOT a requirement if applying during an Open Enrollment or Guaranteed Issue Period**
- Complete Replacement Notice (T05_423) and leave a copy with the applicant (if applicable)**

**Please provide additional information and comments
in the space provided on the application.**

Note: An interviewer may call to verify/confirm the information provided on the application.



| PLAN INFORMATION (to be completed by Producer) | |
|---|---|
| NOTE: For ALL sections, ONLY complete the Applicant B information if to be insured. | |
| APPLICANT | APPLICANT B |
| Policy Form | Policy Form |
| Requested Effective Date | Requested Effective Date |
| Premium Collected (based on age at application date) \$ The initial premium includes a one-time policy fee of \$25.00. | Premium Collected (based on age at application date) \$ The initial premium includes a one-time policy fee of \$25.00. |
| Initial Mode A, S, Q, ACH | Initial Mode A, S, Q, ACH |
| Renewal \$ | Renewal \$ |
| Renewal Mode A, S, Q, B (direct monthly not available) | Renewal Mode A, S, Q, B (direct monthly not available) |
| 1. PLEASE READ THE FOLLOWING CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY. | |
| Applicant | Applicant B |
| Name (First/Middle/Last) | Name (First/Middle/Last) |
| Residence Address | Residence Address (if different from Applicant's) |
| City | City |
| State ZIP | State ZIP |
| Mailing Address (if different from residence address) | Mailing Address (if different from residence address) |
| City | City |
| State ZIP | State ZIP |
| Home Phone No () (area code) | Home Phone No () (area code) |
| Current Age Date of Birth / / mo day yr | Current Age Date of Birth / / mo day yr |
| Male <input type="checkbox"/> Female <input type="checkbox"/> | Male <input type="checkbox"/> Female <input type="checkbox"/> |
| Social Security No | Social Security No |
| Medicare Health Insurance Card Number (if known) | Medicare Health Insurance Card Number (if known) |
| E-mail Address | E-mail Address |
| Height Weight Ft In Lbs | Height Weight Ft In Lbs |

2. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

| | | |
|--|--|--|
| 1. Have you received a copy of the Guide to Health Insurance for People with Medicare and the Outline of Coverage? | Applicant Yes <input type="checkbox"/> No <input type="checkbox"/> | Applicant B Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Have you used tobacco in any form in the past 12 months? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| To the Best of Your Knowledge: | | |
| 1. Are you covered under Medicare Part A? If "YES," what is your Part A effective date? _____ Applicant / / Applicant B / / | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If "NO," what is your eligibility date? _____ Applicant / / Applicant B / / | | |
| 2. Are you covered under Medicare Part B? If "YES," what is your Part B effective date? _____ Applicant / / Applicant B / / | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If "NO," indicate date you plan to enroll. _____ Applicant / / Applicant B / / | | |
| 3. Did you turn age 65 in the last six months? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Did you enroll in Medicare Part B in the last six months? If "YES," indicate your effective date. _____ Applicant / / Applicant B / / | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.**

3. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

| | | |
|--|--|--|
| To the Best of Your Knowledge: | | |
| 1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.) | Applicant Yes <input type="checkbox"/> No <input type="checkbox"/> | Applicant B Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force? (a) If "YES," with what company, and what plan do you have? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

| | |
|---------------------------|---------------------------|
| Applicant | Applicant B |
| Name of Company | Name of Company |
| Policy/Certificate Number | Policy/Certificate Number |
| Plan | Plan |
| Issue Date / / | Issue Date / / |

| | | |
|---|--|--|
| (b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (c) If "YES," indicate termination date. _____ Applicant / / Applicant B / / | | |
| (d) If "YES," have you received a copy of the replacement notice? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4. | | |
| 3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START _____ / / END _____ / / START _____ / / END _____ / / Applicant / / Applicant B / / | | |
| (a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (b) If "YES," have you received a copy of the replacement notice? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| (c) Reason for termination/disenrollment? _____ Applicant / Applicant B / | | |
| (d) Planned date of termination/disenrollment? _____ Applicant / / Applicant B / / | | |

If you are applying during Open Enrollment or a Guaranteed Issue period, **SKIP SECTION 4 and GO TO SECTION 5.**

4. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. Make sure all questions are answered by each applicant. If either you or Applicant B answer "YES" to any of the following questions 1-14, that person is not eligible for coverage.

| To the Best of Your Knowledge: | Applicant | Applicant B |
|---|--|--|
| 1. Are you currently hospitalized or confined to a nursing facility; or, are you bedridden or confined to a wheelchair? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? If you do not have diabetes, this question should be answered "NO". | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 7. Do you have diabetes that has ever required more than 50 units of insulin daily? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 13. Have you been hospital confined three or more times in the last two years? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 14. Have you had an organ transplant or been advised by a physician to have an organ transplant? | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |
| 15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please list the drug and the condition in the following table. | Yes <input type="checkbox"/> No <input type="checkbox"/> | Yes <input type="checkbox"/> No <input type="checkbox"/> |

| Applicant (please attach a separate sheet if needed) | Applicant B (please attach a separate sheet if needed) |
|--|--|
| Medication Name (copy off pharmacy label) | |
| Date Originally Prescribed | |
| Frequency and Dosage | |
| Diagnosis/Condition | |
| Medication Name (copy off pharmacy label) | |
| Date Originally Prescribed | |
| Frequency and Dosage | |
| Diagnosis/Condition | |
| Medication Name (copy off pharmacy label) | |
| Date Originally Prescribed | |
| Frequency and Dosage | |
| Diagnosis/Condition | |

5. PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstated if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstated policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I wish to apply for a Medicare supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, upon acceptance of the completed application, each applicant will receive a separate policy. I understand that my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Columbian Mutual Life Insurance Company.

Dated at _____, on _____, _____, _____, _____
City State Month Day Year Applicant's Signature

Dated at _____, on _____, _____, _____, _____
City State Month Day Year Applicant B's Signature (if applying)

Premium Must Accompany Application

I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

(Signature of Licensed Producer) _____ (Date) _____ (Signature of Licensed Producer) _____ (Date) _____
Dann Loewenthal
PRODUCER STAMP PRODUCER STAMP



**COLUMBIAN MUTUAL
LIFE INSURANCE COMPANY**

Home Office: Binghamton, NY 13902
Administrative Service Office: P.O. Box 2620
Omaha, NE 68103-2620

Calculate Your Premium
Medicare Supplement

Medicare Supplement Plan _____

Before you begin: If you're not in your open enrollment or guarantee issue period, please go to page 2 to determine your eligibility for coverage.

| Line | Steps | Example Rate displayed is used for calculation purposes only. | Applicant's Premium | Applicant B's Premium |
|------|--|--|------------------------|--------------------------|
| #1 | Premium Write in your Med supp plan's premium from the Outline of Coverage provided. | \$128.52 | | |
| #2 | Payment Options To determine other payment schedules, multiply your monthly premium by: 3 to pay 4 times a year (quarterly) 6 to pay twice a year (semiannually) 12 to pay once a year (annually) | \$128.52 monthly payment \$385.56 quarterly payment \$771.12 semiannual payment \$1,542.24 annual payment | | |
| #3 | Enrollment/Policy Fee There is a one-time application fee of \$25.00. This will be collected with your initial payment and will NOT affect your renewal premium amounts. | \$128.52 + \$25.00 = \$153.52 Example shows initial payment (monthly schedule). | | |

Complete and return with application

Height and Weight Chart

Eligibility

To determine whether you may purchase coverage, locate your height, then weight in the chart below. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time. If your weight is located in the Standard column, you may continue to step 1.

| | Decline | Standard | Decline |
|--------|---------|-----------|---------|
| Height | Weight | Weight | Weight |
| 4' 2" | < 54 | 54 – 145 | 146 + |
| 4' 3" | < 56 | 56 – 151 | 152 + |
| 4' 4" | < 58 | 58 – 157 | 158 + |
| 4' 5" | < 60 | 60 – 163 | 164 + |
| 4' 6" | < 63 | 63 – 170 | 171 + |
| 4' 7" | < 65 | 65 – 176 | 177 + |
| 4' 8" | < 67 | 67 – 182 | 183 + |
| 4' 9" | < 70 | 70 – 189 | 190 + |
| 4' 10" | < 72 | 72 – 196 | 197 + |
| 4' 11" | < 75 | 75 – 202 | 203 + |
| 5' 0" | < 77 | 77 – 209 | 210 + |
| 5' 1" | < 80 | 80 – 216 | 217 + |
| 5' 2" | < 83 | 83 – 224 | 225 + |
| 5' 3" | < 85 | 85 – 231 | 232 + |
| 5' 4" | < 88 | 88 – 238 | 239 + |
| 5' 5" | < 91 | 91 – 246 | 247 + |
| 5' 6" | < 93 | 93 – 254 | 255 + |
| 5' 7" | < 96 | 96 – 261 | 262 + |
| 5' 8" | < 99 | 99 – 269 | 270 + |
| 5' 9" | < 102 | 102 – 277 | 278 + |
| 5' 10" | < 105 | 105 – 285 | 286 + |
| 5' 11" | < 108 | 108 – 293 | 294 + |
| 6' 0" | < 111 | 111 – 302 | 303 + |
| 6' 1" | < 114 | 114 – 310 | 311 + |
| 6' 2" | < 117 | 117 – 319 | 320 + |
| 6' 3" | < 121 | 121 – 328 | 329 + |
| 6' 4" | < 124 | 124 – 336 | 337 + |
| 6' 5" | < 127 | 127 – 345 | 346 + |
| 6' 6" | < 130 | 130 – 354 | 355 + |
| 6' 7" | < 134 | 134 – 363 | 364 + |
| 6' 8" | < 137 | 137 – 373 | 374 + |
| 6' 9" | < 140 | 140 – 382 | 383 + |
| 6' 10" | < 144 | 144 – 392 | 393 + |
| 6' 11" | < 147 | 147 – 401 | 402 + |
| 7' 0" | < 151 | 151 – 411 | 412 + |
| 7' 1" | < 155 | 155 – 421 | 422 + |
| 7' 2" | < 158 | 158 – 431 | 432 + |
| 7' 3" | < 162 | 162 – 441 | 442 + |
| 7' 4" | < 166 | 166 – 451 | 452 + |

Medicare supplement insurance is underwritten by

Columbian Mutual Life Insurance Company

Administrative Service Office

P.O. Box 2620

Omaha, Nebraska 68103-2620

<https://www.cfglife.com/partners/medsupp/home>



**COLUMBIAN MUTUAL
LIFE INSURANCE COMPANY**

Home Office: Binghamton, NY 13902
Administrative Service Office: P.O. Box 2620
Omaha, NE 68103-2620

Policy Delivery

Mail policy/policies to:

- (a) Applicant Producer
- (b) Applicant B Producer

Producer(s) Information

Producer Name Dann Loewenthal Social Security No _____
 Comm. % Share _____ Producer Phone No (541) 434.9613 Commission Code _____
 Producer E-mail Address dann @ lowinsure.com
 Producer FAX Number 541.284.2994

Producer Name _____ Social Security No _____
 Comm. % Share _____ Producer Phone No (____) _____ Commission Code _____
 Producer E-mail Address _____ @ _____
 Producer FAX Number _____

Producer To Complete Only If Premium Is To Be Paid With A Business Check/Account

Initial Payment

- | | | |
|---|--------------------------|--------------------------|
| Is the applicant: | Yes | No |
| (a) unemployed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) employed, but not working for the business that is paying the premium?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) the business owner or spouse of the business owner?..... | <input type="checkbox"/> | <input type="checkbox"/> |

If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

Renewal Payment

- | | | |
|---|--------------------------|--------------------------|
| Is the applicant: | Yes | No |
| (a) unemployed?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) employed, but not working for the business that is paying the premium?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) the business owner or spouse of the business owner?..... | <input type="checkbox"/> | <input type="checkbox"/> |

If (a), (b), or (c) is "Yes," the premium can be paid with a business check/account.

Authorization To Disclose Personal Information To Columbian Mutual Life Insurance Company

Meanings of Terms

"Medical Persons and Entities" means: all physicians, medical or dental practitioners, hospitals, clinics, pharmacies, pharmacy benefit managers, other medical care facilities, health maintenance organizations and all other providers of medical or dental services.

"Personal Information" means: all health information, such as medical history, mental and physical condition, prescription drug records, drug and alcohol use and other information such as finances, occupation, general reputation and insurance claims information about me. Personal Information does not include Psychotherapy Notes.

"Psychotherapy Notes" means: notes recorded by a health care provider who is a mental health professional documenting or analyzing the contents of conversation during a counseling session, which notes are separated from the rest of the person's medical record. Certain information, such as that relating to prescriptions, diagnosis and functional status, is not included in the term Psychotherapy Notes.

"Specified Companies" means:

- The group of companies which presently includes Columbian Mutual Life Insurance Company and additional companies which may become part of this group of companies and their successors.
- Other persons and entities which act on behalf of those companies to provide services to them.

Authorization to Disclose

I authorize the Medical Persons and Entities, the Specified Companies, employers, consumer reporting agencies and other insurance companies to disclose Personal Information about me to Columbian Mutual Life Insurance Company.

Purposes

The Personal Information will be used to determine my eligibility for insurance and to resolve or contest any issues of incomplete, incorrect or misrepresented information on my application which may arise during the processing of my application or in connection with claims for insurance benefits.

Potential for Redisclosure

If the person or entity to whom Personal Information is disclosed is not a health care provider or health plan subject to federal privacy regulations, the Personal Information may then be subject to further disclosure by that person or entity without the protections of the federal privacy regulations.

Failure to Sign

I understand that I may refuse to sign this authorization. I realize that if I refuse to sign, the insurance for which I am applying will not be issued.

Expiration and Revocation

Unless revoked earlier, this authorization will remain in effect for 24 months from the date I sign it. I understand that I may revoke this authorization at any time, by written notice to:

ATTN: Individual Underwriting
Columbian Mutual Life Insurance Company
P.O. Box 2620
Omaha, Nebraska 68103-2620

I realize that my right to revoke this authorization is limited to the extent that Columbian Mutual Life Insurance Company has taken action in reliance on the authorization or the law allows Columbian Mutual Life Insurance Company to contest the issuance of the policy or a claim under the policy.

Copy

I understand that I will receive a copy of the signed authorization. A copy of this authorization is as effective as the original.

Applicant acknowledges and agrees that if there is more than one proposed insured on this application, all information provided may be reviewed or shared with the other applicant. A completed and signed application will become part of each applicant's policy.

Names and Signatures

Name(s) used for medical records (if different than the name(s) below): _____

| Applicant | Applicant B |
|------------------------------------|------------------------------------|
| Printed Name of Proposed Applicant | Printed Name of Proposed Applicant |
| Signature of Proposed Applicant | Signature of Proposed Applicant |
| Date | Date |

**COLUMBIAN MUTUAL
LIFE INSURANCE COMPANY**

Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage

Save this notice! It may be important to you in the future.

According to your application, you intend to terminate existing Medicare supplement or Medicare Advantage insurance and replace it with a policy to be issued by Columbian Mutual Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

Statement to Applicant by Issuer, Agent, Broker or Other Representative:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

| Applicant | Applicant B |
|--|--|
| <input type="checkbox"/> Additional benefits | <input type="checkbox"/> Additional benefits |
| <input type="checkbox"/> No change in benefits, but lower premiums | <input type="checkbox"/> No change in benefits, but lower premiums |
| <input type="checkbox"/> Fewer benefits and lower premiums | <input type="checkbox"/> Fewer benefits and lower premiums |
| <input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D | <input type="checkbox"/> My plan has outpatient prescription drug coverage and I am enrolling in Part D |
| <input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment | <input type="checkbox"/> Disenrollment from a Medicare Advantage Plan Please explain reason for disenrollment |
| <input type="checkbox"/> Other (please specify) | <input type="checkbox"/> Other (please specify) |
| _____ | _____ |
| _____ | _____ |
| _____ | _____ |

If you still wish to terminate your present policy or certificate and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy or certificate until you have received your new policy and are sure that you want to keep it.

X _____
Signature of Agent, Broker or Other Representative

Columbian Mutual Life Insurance Company, P.O. Box 2620, Omaha, Nebraska 68103-2620

| Applicant | Applicant B |
|------------------|--------------------|
| Signature | Signature |
| Date | Date |



**COLUMBIAN MUTUAL
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Initial Premiums Paid through Automated Clearing House (ACH)

Medicare supplement applications may have their initial premiums automatically deducted from their checking or savings account through the specific Electronic Funds Transfer (EFT) process identified as Automatic Clearing House (ACH). When they do, you may fax the application and required forms instead of mailing them.

Follow these easy steps to submit Med supp apps using ACH for initial premiums:

Step 1 - Complete the Authorization for Electronic Funds Transfer (ACH/BSP) form

Applicants wishing to pay electronically complete the appropriate Med supp *Authorization for Electronic Funds Transfer* form*:

T05_420 for Columbian Mutual Life Insurance Company

To Pay:

- Only the **initial** premium via EFT, complete the top portion as well as the account information on the Med supp *Authorization for Electronic Funds Transfer* form
- Both the **initial and renewal** premiums via EFT, complete the entire form, including the account information

Step 2 - Fax the following items to the dedicated line for ACH payments at 1-866-422-9139

1. ACH fax transmittal cover sheet on the back of this form, T05_421*
2. Med supp *Authorization for Electronic Funds Transfer* form, T05_420*
3. Med supp application and other required forms

Tips for Submitting Initial Premiums through ACH

- Do not send a signed check for the initial premium; clients could be charged twice
- Do not fax the forms more than once; additional charges could result
- If you fax the forms, do not mail them, too; processing errors occur and additional charges result

*In the application package

For producer use only. Not for use with the general public.

Instructions for Completion of Authorization for Electronic Funds Transfer (ACH/BSP) Form

| | | | | | | | | | | | | | | | | | |
|--|------------------------|---|--|----------------|--|---------------------|-------------|---------------|--|---------------|--|---------------------|--|------------|------------------|-------------------------------|--|
| Account Holder Name | Check Number | | | | | | | | | | | | | | | | |
| <div style="border: 2px solid black; padding: 10px; margin: 10px auto; width: 80%;"> <table style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 60%;">John Doe</td> <td style="width: 40%; text-align: right;">Check #1234</td> </tr> <tr> <td>Street Address</td> <td></td> </tr> <tr> <td>Town, City Zip code</td> <td style="text-align: right;">Date: _____</td> </tr> <tr> <td colspan="2">Pay to: _____</td> </tr> <tr> <td colspan="2" style="text-align: right;">_____ Dollars</td> </tr> <tr> <td colspan="2">Bank Name & Address</td> </tr> <tr> <td>Memo _____</td> <td>Signed By: _____</td> </tr> <tr> <td colspan="2" style="text-align: center;"> ⑆123456789⑆ 12345678 ⑆ 1234 ⑆ </td> </tr> </table> </div> | | John Doe | Check #1234 | Street Address | | Town, City Zip code | Date: _____ | Pay to: _____ | | _____ Dollars | | Bank Name & Address | | Memo _____ | Signed By: _____ | ⑆123456789⑆ 12345678 ⑆ 1234 ⑆ | |
| John Doe | Check #1234 | | | | | | | | | | | | | | | | |
| Street Address | | | | | | | | | | | | | | | | | |
| Town, City Zip code | Date: _____ | | | | | | | | | | | | | | | | |
| Pay to: _____ | | | | | | | | | | | | | | | | | |
| _____ Dollars | | | | | | | | | | | | | | | | | |
| Bank Name & Address | | | | | | | | | | | | | | | | | |
| Memo _____ | Signed By: _____ | | | | | | | | | | | | | | | | |
| ⑆123456789⑆ 12345678 ⑆ 1234 ⑆ | | | | | | | | | | | | | | | | | |
| Bank Routing/ Transfer Number | Bank Account Number | Check Number (if shown at bottom, may be before or after the account #) | Do NOT include the check number as part of either the Routing or Account Number. | | | | | | | | | | | | | | |

The applicant may select one of three payment options indicated on the back side of this form. Instructions for each option are listed below. With each option, the form must be signed and dated.

Option A: Pay all premiums (1st month and monthly renewals) by Electronic Funds Transfer (EFT). Automatic Clearing House (ACH) is used for initial payment and Bank Service Plan (BSP) is used for renewal payments. When choosing to pay both the initial and monthly renewals by EFT, the applicant must complete the form and submit it with the application. **DO NOT** submit a signed check for payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account numbers, name of financial institution) on the form.

Option B: Pay 1st month by paper check and monthly renewals by BSP
When choosing to pay the initial premium via paper check and the monthly renewals by BSP, the applicant must complete the form and submit it with the application. A signed check for the initial monthly premium must be submitted with the application.

Option C: Pay 1st month by ACH and pay renewals by direct bill (monthly direct billing is not offered)
When choosing to pay the initial premiums by ACH and renewal premiums by direct billing (quarterly, semiannually, or annually), the applicant must complete the form and submit it with the application. **DO NOT** submit a signed check for the initial premium payment under this option. To avoid potential delays in processing, submit a voided check and complete the account information (routing/account number, name of financial institution) on the form.

When choosing to pay initial premiums by ACH, money will be withdrawn on the date the application is processed. This may be different from the monthly withdraw date selected for renewal premiums.

Payments cannot be postponed until a later date.

Payment from a third party, including any foundation, cannot be accepted.

All refunds will be made to the applicant in the event of rejection, incomplete submission, overpayment, cancellation, etc.

Please complete the Electronic Funds Transfer form accurately and in its entirety, making sure that all required information is correct and complete on your Electronic Funds Transfer form prior to submission. In addition, please make sure that the premium amount is filled in on the Electronic Funds Transfer form so we can initiate a timely and accurate withdrawal from your client's bank account.

An example of how to find correct Routing and Account Numbers on your clients' checks is included at the top of this form. Do not include the check number as part of either the Routing or Account Number. The applicant's bank name is normally included above the Memo line on the check.



COLUMBIAN MUTUAL
LIFE INSURANCE COMPANY

Home Office: Binghamton, NY 13902
Administrative Service Office: P.O. Box 2620
Omaha, NE 68103-2620

Please refer to instructions
on the Front of this form.

Authorization for Electronic Funds Transfer (ACH/BSP)

This form is intended as authorization to debit your account. Please complete initial and renewal premium payment information below.

Medicare Supplement Premium Payment Options:

| | Applicant A | | Applicant B | |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| | YES | NO | YES | NO |
| A. Pay premiums (1st month and monthly renewals) by Electronic Funds Transfer (ACH is used for initial payment and BSP is used for renewal payments.) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| B. Pay 1st premium by signed paper check and pay monthly renewals by BSP | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| C. Pay initial premium by ACH and pay renewals by direct bill (monthly direct billing is not offered) | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • If choosing Options A or C, list amount of initial premium withdrawal | \$ _____ | | \$ _____ | |
| • If choosing Options A or B, select a withdrawal date for monthly renewal payments (circle one) | 1st or 15th | | 1st or 15th | |
| • Is a Business Account being used to pay premiums? | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| • If yes, is the applicant: | | | | |
| (a) Unemployed | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (b) Employed, but not working for the business that is paying the premium | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| (c) The business owner or spouse of the business owner | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

If (A), (B), or (C) are "Yes," premiums CAN be paid with a business account.

Applicant A

Applicant B

Complete the information below. To avoid potential delays in processing, submit a copy of a voided check.

Account Type (check one): Checking Savings

Account Type (check one): Checking Savings

Name of Financial Institution

Name of Financial Institution

Routing Number (first 9 digits on lower left side of check)

Routing Number (first 9 digits on the lower left side of check)

Account Number
(Do NOT use Debit or Credit Card account numbers)

Account Number
(Do NOT use Debit or Credit Card account numbers)

Name as Shown on Account

Name as Shown on Account

IMPORTANT: Withdrawal date of the initial premium payment will occur when the application is processed and may be different than the monthly withdrawal date selected above.

I authorize Columbian Mutual Life Insurance Company ("Columbian Mutual") to withdraw funds from my account for my initial and/or monthly renewal premiums and understand that the amounts may differ. I also authorize Columbian Mutual to collect any premium(s) due by bank draft withdrawal. Premium shortages may result from a variety of causes, including underwriting adjustments. I authorize you, my financial institution, to pay from my account any checks, drafts or preauthorized electronic fund transfers from my account to Columbian Mutual. Your rights with each charge will be the same as if personally paid by me. The authorization will be effective until I give you at least three business days' notice to cancel it. If notice is given verbally, you may require written confirmation from me within 14 days after my verbal notice.

Authorized Signature as Shown on Account

Authorized Signature as Shown on Account

Date

Date