

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

Proposed Insured Section							
Proposed Insured's Name (First, MI, Last)		Employee <input type="checkbox"/>	Spouse <input type="checkbox"/>	Dependent <input type="checkbox"/>	Gender M <input type="checkbox"/> F <input type="checkbox"/>	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 <input type="checkbox"/> F <input type="checkbox"/>	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 <input type="checkbox"/> Contingent <input type="checkbox"/>	Age	Benefit %	Relationship to Proposed Insured	Social Security No.
Beneficiary's Name (First, MI, Last)		Primary <input type="checkbox"/> Contingent <input type="checkbox"/>	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 <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			
	M <input type="checkbox"/> F <input type="checkbox"/>			

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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Is the Proposed Insured actively working?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
2.a. If "No", is the Proposed Insured disabled or unable to work?	Yes <input type="checkbox"/> No <input type="checkbox"/>	
3. Is your spouse disabled or unable to work?		Yes <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> A <input type="checkbox"/> B (UL only)	
			Automatic Premium Loan if available? Yes <input type="checkbox"/> No <input type="checkbox"/>	Planned Premium \$ _____
			Settlement Option	Rider Premium \$ _____
Total Monthly Premium \$				
Method of Payment (if other than payroll deducted) <input type="checkbox"/> Bank Draft <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly				

Life Adjustment				
<input type="checkbox"/> Existing Policy Number _____	<input type="checkbox"/> Increase	<input type="checkbox"/> Tobacco to Non-tobacco Policy	<input type="checkbox"/> Option Change (UL only)	<input type="checkbox"/> Rider Conversion
	<input type="checkbox"/> Rider Addition	<input type="checkbox"/> Exercising Guaranteed Purchase Option	<input type="checkbox"/> Term Life 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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>

AIDS Section	Proposed Insured	Your Spouse	Your Dependent
7. Have you or any person applying for coverage tested positive for exposure to the HIV infection, or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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)		

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	Your Dependent
Indicate Your Dependent 's current: Height _____ Weight _____	
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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>

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 <input type="checkbox"/> No <input type="checkbox"/>		
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 <input type="checkbox"/> No <input type="checkbox"/>		
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 _____ Driver's license number _____ State of issue _____	Yes <input type="checkbox"/> No <input type="checkbox"/>		
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: 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 <input type="checkbox"/> No <input type="checkbox"/> If yes, list type of group _____	Yes <input type="checkbox"/> No <input type="checkbox"/>		
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) _____ Date (s) _____ Are you currently on probation? Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>		
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 High Blood Pressure Asthma, Emphysema, Lung or Respiratory Disorder Circulatory, Heart, Blood Vessel Disease or Disorder Stroke Liver Disease or Disorder Heart Murmur Paralysis Gastrointestinal or Digestive Disease or Disorder Blood Disease or Lymph Node Disorder Epilepsy Kidney or Genitourinary Disease or Disorder Heart Attack (MI) Thyroid Disorder Nervous or Mental Disorder Chest Pain / Angina Diabetes Skin, Bone, Muscle or Joint Disorder	Yes <input type="checkbox"/> No <input type="checkbox"/>		
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 <input type="checkbox"/> No <input type="checkbox"/>		
23. 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

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Agreement Section

THE PROPOSED INSURED AGREES AS FOLLOWS:

All statements and information found in the application are deemed representation and not warranties. Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete or misleading information is guilty of a felony of the third degree. 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 within the first two years after the coverage effective date. 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. Yes No

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

Agent's Phone No. (____) _____

Agent's Report

Questions 1 – 3 must always be answered

- 1a. Check medical requirements:
 Non-medical H.O. specimen Blood Exam ECG
- 1b. Are medical requirements being arranged by:
 Home Office Producer
2. Was the proposed insured present and observed by you at the time of the application? Yes No
 If "No", medical examination required. (see question #1.)
3. Has the Fair Credit Reporting Act and Medical Information Bureau Notice been delivered? Yes No
- 4a. Is this Business Insurance? Yes No
 If "Yes", give details in 4b and 4c.
- 4b. Purpose of Insurance Key Employee Buy-Sell Other

4c. Owners of the Business	Percent of Business Ownership	Amount of Business Insurance

If applying for juvenile insurance, complete numbers 5 and 6.

5. List amounts of any life insurance on: Father: \$_____ Mother: \$_____
6. Is there equal life insurance coverage on all dependent children? Yes No
- If no, give details: _____

Agent's Remarks:

 Agent's Name (If Present) _____
 Please Print

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

DETACH AND LEAVE WITH APPLICANT.

This Notice must be given to Proposed Insured

(Including Medical Information Bureau Notice and Fair Credit Reporting Act Notice)

In considering Your application, information from various sources will be considered. These include Your statements, the results of Your physical examination (if required), and reports we get from doctors or medical facilities which have attended to You.

MEDICAL INFORMATION BUREAU, INC. (MIB)

Pre-Notice: Information about Your insurability will be treated as confidential. We, or our reinsurers, may, however, make a brief report thereon to MIB, a not for profit membership organization of insurance companies, which operates an information exchange on behalf of its Members. If You apply to another MIB Member company for life or health insurance coverage, or a claim for benefits is submitted to such company, MIB, upon request, will supply such company with the information in its file.

Upon receipt of a request from You, MIB will arrange disclosure of any information it may have in Your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If You question the accuracy of information in MIB's file, You may contact MIB and seek a correction in accordance with the procedures set for in the federal Fair Credit Reporting Act. This address of MIB's information office is Post Office Box 105, Essex Station, Boston Massachusetts 02112.

We, or our reinsurers, may also release information in our file to other insurance companies to whom You may apply for life or health insurance, or to whom a claim for benefits may be submitted.

COMPLIANCE NOTICE

We appreciate Your application for insurance coverage. We wish to inform You that an investigative consumer report may be ordered as to Your insurability. This report may include, if applicable, information as to Your character, general reputation, personal characteristics, and mode of living as may be obtained through interviews with family members, friends, neighbors and associates. You may also request to be interviewed in connection with its preparation. If You would like to know whether such a report was ordered and, if so, receive additional information as to its nature and scope including the name, address and phone number of the reporting agency, we will be pleased to furnish this information upon Your written request to the address below. You may also receive a copy of such report by making written request to us, Your agent or the reporting agency after proper identification.

Privacy Notice

Personal information may be collected from persons other than You. Such information, as well as other personal or privileged information subsequently collected by us or Your broker may in certain circumstances be disclosed to third parties without authorization and to affiliates of the company only as permitted by law. You have a right of access and correction with respect to all personal information collected. A detailed notice of information practices will be furnished to You upon request.

If you need any assistance, please feel free to contact Your broker or call or write to:

Privacy Officer, UnumProvident Corporation, 2211 Congress Street, M347, Portland, Maine 04122.

