Application for Individual Life Insurance to:
COLONIAL LIFE & ACCIDENT INSURANCE COMPANY PO Box 1365 Columbia, SC 29202

Proposed Insured Section

Proposed Insured's Name (First, MI, Last)	Employee ☐ Spouse ☐ Juvenile ☐	Gender M ☐ F ☐	Birthdate (mm/dd/yyyy)	Social Security No.
Home Address – Street (Not a 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

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.

Spouse and/or Dependent Children(s) Rider Section - if additional space is needed, please use the Additional Data Section

Name (First, MI, Last)	Gender	Birthdate (mm/dd/yyyy)	Relationship	Social Security No.
	M ☐ F ☐			
	M ☐ F ☐			
	M ☐ F ☐			
	M ☐ F ☐			
	M ☐ F ☐			

Beneficiary Section – if additional space is needed, please use the Additional Data 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.

Term or Whole Life	Base Plan Code and Premium	Face Amount	Rider Plan Code and Units	Rider Premium	Total Monthly Premium
Automatic Premium Loan if available for Whole Life? Yes ☐ No ☐	$	$			$

Universal Life	Base Plan Code and Target Premium	Face Amount	Rider Plan Code and Units	Rider Premium	Total Monthly Premium
Option A ☐ B ☐	$	$			Planned Premium $ $

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

NOTE: 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.

Eligibility Questions - required for all face amounts	Proposed Insured	Your Spouse
1. Within the past 12 months, have you used any tobacco products (cigarettes, cigars, snuff, dip, chew, pipe) and/or any nicotine delivery system?	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 (if applying for coverage) disabled or unable to work?		Yes ☐ No ☐

Replacement Section - complete replacement form if required in your state	
4. Does the Proposed Insured have any existing life coverage? If yes, provide details below and complete form if applicable in your state.	Yes ☐ No ☐
5. Will any life insurance or annuities with this or any other company be replaced or changed if the coverage applied for is issued? If yes, check appropriate box of policy being replaced, modified or discontinued and complete form if applicable in your state.	Yes ☐ No ☐

Insured's Name	Insurance Company Name and Address	Policy Number	Amount of Coverage	Check yes if policy replaced
				Yes ☐ No ☐ Yes ☐ No ☐ Yes ☐ No ☐

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. This question applies to Universal Life Only.	Yes ☐ No ☐

AIDS Section – Required for all face amounts	Proposed Insured	Your Spouse
7. Have you, or your spouse if applying for spouse coverage, tested positive for the Human Immunodeficiency Virus (HIV) or its antibodies, or been diagnosed by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-related complex (ARC)?	Yes ☐ No ☐	Yes ☐ No ☐

Simplified Issue (SI)	Proposed Insured	Your Spouse
8. Within the past 12 months, have you, or your spouse if applying for spouse coverage, been hospitalized or missed 5 or more consecutive days of work for any reason other than flu, pregnancy, accidents, allergies, back or knee disorder? If yes, answer Simplified Issue Level One questions.	Yes ☐ No ☐	Yes ☐ No ☐

~~Simplified Issue Level One (SI1)~~	~~Proposed Insured~~	~~Your Spouse~~
~~Indicate Your Current:~~ ~~Height_____~~ ~~Weight_____~~ ~~Indicate Your Spouse's Current:~~ ~~Height_____~~ ~~Weight_____~~		
~~9. 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 member of the medical profession; received medical advice or sought treatment by a member of the medical profession for drug and/or alcohol abuse; or been advised by a member of the medical profession to reduce your consumption of drugs or alcohol?~~	~~Yes ☐ No ☐~~	~~Yes ☐ No ☐~~
~~10. Within the past 24 months, have you, or your spouse if applying for spouse coverage, been convicted of 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, or are you currently on probation or parole?~~	~~Yes ☐ No ☐~~	~~Yes ☐ No ☐~~
~~11. Within the past 24 months, have you, or your spouse if applying for spouse coverage, been prescribed 3 or more medications by a member of the medical profession (including diuretic) for high blood pressure; or been prescribed medication for high blood pressure and diagnosed with diabetes by a member of the medical profession?~~	~~Yes ☐ No ☐~~	~~Yes ☐ No ☐~~
~~12. Within the past 10 years, have you, or your spouse if applying for spouse coverage, received medical advice or sought treatment by a member of the medical profession for internal cancer, including leukemia or melanoma of Clark's level III or higher?~~	~~Yes ☐ No ☐~~	~~Yes ☐ No ☐~~
~~13. Within the past 5 years have you, or your spouse if applying for spouse coverage, received medical advice or sought treatment by a member of the medical profession (including medication) for:~~ ~~Heart Attack (MI)/Angina~~ ~~Congestive Heart Failure/Cardiomyopathy~~ ~~Emphysema~~ ~~Cardiac/Circulatory Surgery~~ ~~Systemic Lupus (SLE) Disease~~ ~~Multiple Sclerosis~~ ~~Peripheral Vascular Disease~~ ~~Manic Depressive Disorder (Bipolar)~~ ~~Paralysis~~ ~~Stroke~~ ~~Schizophrenia~~ ~~Hepatitis (except A)~~ ~~Chronic Kidney (Renal) Failure~~ ~~Diabetes (excluding diet controlled and gestational)~~ ~~Transient Ischemic Attack (TIA)~~ ~~Chronic Obstructive Pulmonary Disease (COPD)~~	~~Yes ☐ No ☐~~	~~Yes ☐ No ☐~~

Complete height/ weight and question 14 for ages 0 thru 14 for juvenile Universal Life to $50,000. Also answer question 17 when applying for $50,001 to $100,000. Complete height/weight and questions 14, 15 and 16 for ages 15 thru 17 for juvenile Universal Life to $50,000. Also answer question 17 when applying for $50,001 to $100,000.	Juvenile
Indicate the Juvenile 's current: Height _____ Weight _____	
14. Has the juvenile ever received medical advice or sought treatment by a member of the medical profession for cystic fibrosis, diabetes, heart disorder, leukemia, cancer (other than skin cancer), seizures, down's syndrome, cerebral palsy or been hospitalized in the past 12 months for a respiratory illness?	Yes ☐ No ☐
15. Within the past 24 months, has the juvenile used marijuana, cocaine, heroin, or any other illicit drug or controlled substance, with the exception of those prescribed for him by a member of the medical profession; or received medical advice or sought treatment by a member of the medical profession for drug and/or alcohol abuse?	Yes ☐ No ☐
16. Within the past 24 months, has the juvenile been convicted of 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 ☐
17. Within the past 5 years, has the juvenile been confined to a hospital or medical facility, been seen by a member of the medical profession for any reason other than stated on this application, or is he currently taking medication or receiving medical advice from a member of the medical profession ? If yes, provide details in the Health Details Section.	Yes ☐ No ☐

Full Underwriting	Proposed Insured
Indicate Your Current: Height _____ Weight _____	
18. 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 ☐
19. 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 ☐
20. Within the past 5 years, have you had your driver's license revoked or suspended for any reason; been convicted of operating a motor vehicle under the influence of drugs and/or alcohol; or pled guilty to, pled no contest to or been convicted of 3 or more speeding or other moving violations? If yes, provide: Type of violation and date: _____	Yes ☐ No ☐
21. Provide your Driver's license number _____ State of issue _____	
22. 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 member of the medical profession; received medical advice or sought treatment by a member of the medical profession for drug and/or alcohol abuse; or been advised by a member of the medical profession 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 ☐ No ☐ If yes, list type of group _____	Yes ☐ No ☐
23. 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 or parole?	Yes ☐ No ☐ Yes ☐ No ☐
24. Have you ever received medical advice or sought treatment by a member of the medical profession (including medication) for any condition listed below? If yes, provide details in the Health Details Section. Circulatory, Heart, Blood Vessel Disease or Disorder Heart Murmur Heart Attack (MI) Chest Pain / Angina High Blood Pressure Stroke Paralysis Epilepsy Thyroid Disorder Cancer or Tumor including leukemia or melanoma Blood Disease or Lymph Node Disorder Diabetes Skin, Bone, Muscle or Joint Disorder 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	Yes ☐ No ☐
25. Within the past 5 years, have you been confined to a hospital or medical facility, seen a member of the medical profession for any reason other than stated on this application, or are you currently taking medication or receiving medical advice by a member of the medical profession? If yes, provide details in the Health Details Section.	Yes ☐ No ☐
26. Within the next 24 months, do you have any plans for foreign travel? If yes, provide details in the Additional Data Section.	Yes ☐ No ☐

Health Details Section

For yes answers, provide details below.

Condition Name / Medication Name & Dosage	Diagnosis Date and Duration	Doctor/ Hospital Name, Address & Phone No.	Date of Treatment	Type of Treatment Received

Additional Data Section

Caring for the Shepherd Member - Harmony Account #: F6176952

Owner Section - complete this section if you are naming an owner other than the Proposed Insured or if Proposed Insured is a juvenile

Owner (Name and Address)	Relationship	Social Security No.
Contingent Owner (if applicable) (Name and Address)	**Relationship**	**Social Security No.**

Agreement Section

THE PROPOSED INSURED AGREES AS FOLLOWS:

Any person who includes any false or misleading information on an application for an insurance policy is subject to criminal and civil penalties. I have read the application and the answers and statements above are true and complete to the best of my knowledge and belief. 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 due is paid while the Proposed Insured is alive. Items 1 and 2 must occur while any conditions affecting insurability are the same as described above. I understand that any material misrepresentation may result in claim denial or rescission of coverage for two years after the effective date of coverage. If coverage is rescinded, Colonial's only obligation will be to refund all premiums paid. I understand that the statements and answers in this application are the basis for any policy issued by Colonial, and no information about me will be considered to have been given to Colonial unless it is stated in the application.

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)_____
Signature of Proposed Insured

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

Agent Section

Agent's Name (If Present) Dennis Browne
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 further certify that I am a licensed agent in the state where this application is being taken. I understand that I do not have Colonial's authorization to accept risk, pass on insurability, or make, void, waive or change any conditions or provisions of the application, policy or receipt, as applicable.

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)_____
mm/dd/yyyy Signature of Licensed Agent

License No. 8031191 Code No. 726205