

**SUPPLEMENTAL
APPLICATION FOR
CHILDREN'S TERM
INSURANCE RIDER**

COLUMBIAN LIFE INSURANCE COMPANY

HOME OFFICE: CHICAGO, IL

ADMINISTRATIVE SERVICE OFFICE: PO Box 4850, Norcross, GA 30091-4850

This application supplements Application Form No. _____, dated _____.

CHILDREN'S TERM INSURANCE RIDER NUMBER OF UNITS APPLIED FOR: _____

You can apply for coverage on a maximum of 20 children as defined below.

Please attach a 2nd Supplemental Application for Children's Term Insurance to list more than 10 Proposed Insured children.

1. CHILDREN PROPOSED FOR INSURANCE					
<i>Name natural born children, stepchildren, legally adopted children, grandchildren, step grandchildren, legally adopted grandchildren, great grandchildren, step great grandchildren and legally adopted great grandchildren proposed for insurance. Insurance will not be provided on newborn children less than 15 days of age or children that are not US citizens.</i>					
Full Name of Proposed Insured Child	Address and Telephone Number	Date of Birth MM/DD/YYYY	Age Last Birthday	Social Security No.	
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					
2. BENEFICIARY (If a trust, give Trustee Name, Trust Name & Trust Date. If no Beneficiary is named for any child, the Beneficiary Designation defaults to the Insured of the base policy.) Attach a separate sheet if necessary.					
Primary Beneficiary Designation (Full name and address)		Relationship to Insured	Social Security No.		
		Telephone Number	Date of Birth		
Contingent Beneficiary Designation (Full name and address)		Relationship to Insured	Social Security No.		
		Telephone Number	Date of Birth		
3. HEALTH HISTORY				YES	NO
1. Has any child proposed for insurance ever 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)?.....				<input type="checkbox"/>	<input type="checkbox"/>
2. Has any child proposed for insurance ever used or received treatment, advice or counseling from a physician or other practitioner relating to the usage of alcohol, heroin, cocaine, narcotics, hallucinogens, tranquilizers, barbiturates, amphetamines, or other similar drugs except as prescribed by a physician?.....				<input type="checkbox"/>	<input type="checkbox"/>
3. Has any child proposed for insurance ever been diagnosed or treated (including taking medication) for high blood pressure, heart or circulatory disorder, cancer, mental disorder, mental retardation, Down's Syndrome, muscular dystrophy, spina bifida, cystic fibrosis, kidney or liver disease, diabetes, sickle cell anemia, seizures, cerebral palsy, paralysis, had or been recommended for an organ transplant or been hospitalized for asthma or any respiratory disorder in the past twelve (12) months?.....				<input type="checkbox"/>	<input type="checkbox"/>
If any of these questions are answered "YES" that child will be excluded from coverage. Please list the children for which "YES" answers were given:					
4. ACKNOWLEDGEMENT & SIGNATURES					
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.					
_____	X _____				
Date	Signature of Primary Insured				
_____	X _____				
Date	Signature of Licensed Agent				Agent Number