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 AMOUNT OF INSURANCE 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

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.

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 as having or been treated by a member of the medical profession for an Immune Deficiency Disorder, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC), or has any Proposed Insured Child tested positive for Human Immunodeficiency Virus (HIV)?.....	☐	☐
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?.....	☐	☐
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?.....	☐	☐

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

FORM NO. A613TX-CL