



**COLUMBIAN MUTUAL LIFE INSURANCE COMPANY**

HOME OFFICE: BINGHAMTON, NY

ADMINISTRATIVE SERVICE OFFICE: 507 PLUM STREET

PO BOX 1056, SYRACUSE, NY 13201-1056

TELEPHONE: (800) 347-0960 / www.ftlife.com

**APPLICATION FOR  
New Century  
Senior Protector  
Guaranteed Issue Whole Life**

**INCLUDING THE FOLLOWING FORMS:**

- **Application for Electronic Funds Transfer (EFT) Form of Premium Payment – Form No. 5249CFG EFT**

**Instructions to Agents**

- **Insurance age** is calculated based on the Proposed Insured's **age nearest birthday**.
- The "Conditional Receipt" must be completed and given to the Applicant in all cases.
- **A minimum of one months' premium must be submitted with the application.**
- Minimum Annual, Semi-Annual and Quarterly premium is \$25.00.
- Minimum monthly premium is \$15.00.
- Mode premium factors are a fraction of Annual: Semi-Annual = .51; Quarterly = .265; Monthly = .10; EFT = .086
- Automatic Premium Loan (APL) must be answered "yes" or "no".
- A **Social Security or Tax ID Number must be provided** for the Insured and each Owner.
- Issue ages are 50 through 80 (78 in West Virginia).
- Coverage is available in amounts of \$2,000 through \$25,000.
- No other benefits or riders are available.
- Replacement question No. 6 must always be answered.

***CML does not accept replacement business in West Virginia.***



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APPLICATION FOR  
**NEW CENTURY SENIOR PROTECTOR -  
 GUARANTEED ISSUE**

FOR INSURANCE POLICIES ISSUED FOR SMALL FACE AMOUNTS OR WITH LITTLE OR NO UNDERWRITING, THE PREMIUMS ARE OFTEN RELATIVELY EXPENSIVE IN RELATIONSHIP TO THE DEATH BENEFIT PROVIDED. FOR INSURANCE PURCHASES, AS WITH ANY OTHER TYPE OF PURCHASES, IT MAY BE TO YOUR ADVANTAGE TO COMPARE PRODUCTS AND PRICES FROM A NUMBER OF SOURCES.

**1. PROPOSED INSURED**

\_\_\_\_\_  
 First Name Middle Initial Last Name  
 Address \_\_\_\_\_ Social Security No. (Required) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female Telephone (\_\_\_\_) \_\_\_\_\_

**2. SECONDARY ADDRESSEE**

\_\_\_\_\_  
 First Name Middle Initial Last Name  
 Address \_\_\_\_\_ Social Security No. (Required) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  Male  Female Telephone (\_\_\_\_) \_\_\_\_\_

**3.**

<p><b>Amount of Insurance \$</b> _____</p> <p><b>Mode of Premium Payment</b></p> <p><input type="radio"/> Annual <input type="radio"/> Semi-Annual <input type="radio"/> Quarterly  <input type="radio"/> Monthly <input type="radio"/> EFT <input type="radio"/> List Bill</p> <p><b>Automatic Premium Loan, if available:</b> <input type="radio"/> YES <input type="radio"/> NO</p>	<p><b>Dividends</b></p> <p><input type="radio"/> Cash <input type="radio"/> Accumulate at Interest  <input type="radio"/> Reduce Premiums <input type="radio"/> Paid-Up Additions</p> <p><b>Cash with Application</b></p> <p>A minimum of <b>one months'</b> premium is required.  <b>\$</b> _____</p>
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**4. BENEFICIARY:**

Primary: \_\_\_\_\_ Relationship \_\_\_\_\_ Social Security No. \_\_\_\_\_  
 Contingent: \_\_\_\_\_ Relationship \_\_\_\_\_ Social Security No. \_\_\_\_\_

**5. POLICYOWNER, IF OTHER THAN THE INSURED:**

**CO-OWNER:**

Name	Relationship	Name	Relationship
Address	SSN	Address	SSN
City	State Zip	City	State Zip
<p><b>6. Present Life Insurance/Annuity Contracts in Force.</b>            Include Company name and face amount. If none, check here <input type="radio"/>.</p>		<p><b>7. Will any policy applied for replace any existing one in whole or in part?</b> <input type="radio"/> Yes <input type="radio"/> No If Yes, list Company Name(s) and Policy Number(s):</p>	

I agree that: The information above is true and complete to the best of my knowledge and belief; no insurance shall take effect until a policy is issued and the first premium is received by Columbian Mutual Life Insurance Company during my lifetime; and that this application shall form a part of any policy issued.

\_\_\_\_\_  
 Signature of Proposed Insured Date Policyowner, if other than Proposed Insured Date  
 \_\_\_\_\_  
 Signature of Co-owner Date Witness (Agent or Disinterested Third Party) Date



