SENIOR DIRECT *MODIFIED* WHOLE LIFE INSURANCE APPLICATION

SENIOR LIFE INSURANCE COMPANY

SENIOR LIFE INSURANCE COMPANY • PO Box 2447 • Thomasville, GA 31799 • 1-877-777-8808

Proposed Insured _____ SSN _____/_____/_____

Address _____
Street Apt. # City State Zip

Date of Birth _____ Age_____ Gender ❑ Male ❑ Female Height _____ Weight _____

Policy Owner Name _____ SSN _____/_____/_____

Relationship to Proposed Insured _____ Home Telephone (_____) _____

Owner's Email Address _____

Secondary Address *(If different than Insured)* _____
Street Apt. # City State Zip

Primary Beneficiary Name _____
First Middle Last Relationship

Secondary Beneficiary Name _____
First Middle Last Relationship

❑ YES ❑ NO ADB Rider $ _____ Amount of Insurance $ _____ Premium $ _____

PLEASE ANSWER THESE HEALTH QUESTIONS (Must answer "NO" to qualify):

❑ YES ❑ NO Are you currently hospitalized, confined to a nursing facility, receiving hospice care, unable to care for yourself, terminally ill, incarcerated; have you been hospitalized two or more times in the past six months; or do you expect to be admitted to a hospital or nursing facility?

❑ YES ❑ NO Have you tested positive for exposure to the HIV (Human Immunodeficiency Virus) Infection or been diagnosed as having ARC (AIDS Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV (Human Immunodeficiency Virus) Infection or other sickness or condition derived from such infection?

❑ YES ❑ NO Are you legally blind, wheelchair bound, bedridden, on oxygen, or receiving home health care?

❑ YES ❑ NO In the past two years, have you used illegal drugs, been treated for drug/alcohol abuse, been advised by a physician to reduce alcohol consumption, or been noted to excessively consume alcohol?

❑ YES ❑ NO In the past two years, have you had, been treated for, received medical advice by a licensed medical practitioner, been prescribed medication for, or been diagnosed by a licensed medical provider with any heart **and** any lung disease/condition/disorder; any blood, kidney, or liver disease/condition/disorder; Alzheimer's disease; cancer; cerebral palsy; cystic fibrosis; dementia; Huntington's disease; Lou Gehrig's disease; multiple sclerosis; muscular dystrophy; paralysis; stroke; transplant; uncontrolled high blood pressure (or with complications); or uncontrolled diabetes (or with complications)?

Physician/Address: _____ **Medications/Usage:** _____

❑ YES ❑ NO Do you want the Automatic Premium Loan Provision?

❑ YES ❑ NO Do you have any existing life insurance policies or annuity contracts?

❑ YES ❑ NO Will this cause any other insurance or annuity to be replaced or changed? _____
Company Policy #

THIS SECTION AFFECTS YOUR LEGAL RIGHTS

1. THE POLICY FOR WHICH YOU HAVE APPLIED INCLUDES A BINDING ARBITRATION AGREEMENT.
2. THE ARBITRATION AGREEMENT REQUIRES THAT ANY DISAGREEMENT RELATED TO THIS POLICY MUST BE RESOLVED BY ARBITRATION AND NOT IN A COURT OF LAW.
3. THE RESULTS OF THE ARBITRATION ARE FINAL AND BINDING ON YOU AND THE INSURANCE COMPANY.
4. IN ARBITRATION, AN ARBITRATOR; WHO IS AN INDEPENDENT, NEUTRAL PARTY, GIVES A DECISION AFTER HEARING THE POSITIONS OF THE PARTIES.
5. WHEN YOU ACCEPT THIS INSURANCE POLICY YOU AGREE TO RESOLVE ANY DISAGREEMENT RELATED TO THE POLICY BY BINDING ARBITRATION INSTEAD OF A TRIAL IN COURT INCLUDING A TRIAL BY JURY.
6. ARBITRATION TAKES THE PLACE OF RESOLVING DISPUTES BY A JUDGE AND JURY AND THE DECISION OF THE ARBITRATOR CANNOT BE REVIEWED IN COURT BY A JUDGE AND JURY.

ACKNOWLEDGMENT OF ARBITRATION AGREEMENT AND APPLICATION

I have read or have been read the above disclosure. I understand that I am voluntarily surrendering my right to have any disagreement between me and the insurance company resolved in court. This means I am waiving my right to trial by jury. I understand that upon receipt of the policy I should read the arbitration provision contained in the policy and that I have the right to reject this policy within three (3) days of the date of delivery if I do not want to accept the requirement for arbitration. I understand that this same type of insurance may be available through an insurance company that does not require that policy related disagreements be resolved by binding arbitration.

FIRST YEAR 110% of premiums paid SECOND YEAR 110% of premiums paid THIRD YEAR Amount of Insurance

Also, I have read or have been read all questions and answers, and I affirm that they are true to the best of my knowledge and belief. I understand that for insurance to go into effect, the Proposed Insured's health condition must remain as described in the application at the time the first premium is honored by the bank and the policy is issued. I also understand that Senior Life Insurance Company will rely on my answers above in issuing any life insurance hereunder and that the agent does not have the authority to waive or modify any question or answer. Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed In _____ Date _____ Time _____

Signature of Owner _____ Signature of Proposed Insured _____

Payment Type	Payment Mode	Due Date
❑ BSP ❑ DB ❑ IW ❑ DC	❑ Monthly ❑ Quarterly ❑ Semi-Annual ❑ Annual	❑1st ❑ 3rd ❑ 5th ❑10th ❑15th ❑ 20th ❑ 25th

BANK SERVICE PLAN AUTHORIZATION

As a convenience to me, I authorize my bank/financial institution or debit card issuer to deduct future payments for this insurance by electronic or other means directly from my account identified below and payable to Senior Life Insurance Company, Thomasville, Georgia. If said account is replaced by another account, this request and authorization shall apply as well. I agree that Senior Life Insurance Company's treatment of each check or ACH debit, and their rights with respect to it, will be the same as if it were signed or initiated personally by me. I also agree that if any check or ACH debit is dishonored for any reason, Senior Life Insurance Company will not be under any liability even though dishonor results in forfeiture of insurance. I understand this authorization is to remain in effect until either Senior Life Insurance Company or I cancel by sending the other party a written request to do so.

❑ **Checking** ❑ **Savings** **Initial Withdrawal Date** _____/_____/_____
(or as soon as possible thereafter)

Name(s) on Account: _____

Bank/Financial Institution Name: _____

Name of Bank Employee verifying savings information: _____ Routing Number (9 digits): _____

Bank Account # _____

Address: _____ City: _____ State: _____ Zip: _____

Phone: (_____) _____

❑ **Visa** ❑ **MasterCard**

Name on Card: _____

Debit Card Account Number: ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ ☐☐☐☐ Expiration Date: _____/_____/_____

X _____ ☐☐☐ (3 - Digit Security Code located on back of card)

Signature of Payor

STATEMENT OF INSURABLE INTEREST - Complete if insuring any person other than self and/or spouse.

❑ YES ❑ NO Do you have insurable interest in the person to be insured?

❑ YES ❑ NO Do you have complete knowledge of the health history of the person to be insured?

❑ YES ❑ NO If you are insuring grandchildren, are all such dependents being insured, and are you responsible for their financial support? If no, please explain: _____

The Proposed Insured is my: ❑ Parent ❑ Child ❑ Other _____

Best time to reach Proposed Insured by phone: _____

My insurable interest in the Proposed Insured's life is as follows:

❑ The Proposed Insured is legally indebted to me in an amount not less than the face amount of the policy applied for.

AGENT STATEMENT

Are there any existing life insurance or annuity contracts on the life of the Proposed Insured? ❑ YES ❑ NO

I certify that each question in all parts of the application was asked and the answers are true and complete and that I have accurately recorded the answers in full as they were given. To the best of my knowledge, replacement ❑ **is** ❑ **is not** involved in this transaction. When required by the laws of the state, I presented and read the applicant a notice regarding replacement.

Agent's Signature: _____ Agent Number: _____

Printed Name: _____ License Number: _____