



## 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 or 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 the presence of HIV (Human Immunodeficiency Virus) antibodies, antigens or the virus or ever been diagnosed or treated by a licensed medical professional for ARC (AIDS Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV (Human Immunodeficiency Virus) Infection?
- ☐ YES ☐ NO In the past six months, have you experienced any unexplained weight loss or weight gain?
- ☐ YES ☐ NO In the past two years, have you had, been treated, received medical advice or prescribed medication for, or been diagnosed with uncontrolled diabetes including any complications from such, uncontrolled high blood pressure, stroke, paralysis, cancer, any heart, organ, or lung disease (including COPD/Emphysema), mental disorder/retardation, disorder of the brain or nervous system, any impairment, disorder, disease, transplant or chronic illness?
- ☐ YES ☐ NO In the past two years, have you been advised or recommended to have any tests, surgery or hospitalization which has not been received or completed, or advised to take medications and have not been compliant?
- ☐ YES ☐ NO In the past five years, have you used illegal drugs, been treated for drug/alcohol abuse, been advised by a physician to reduce alcohol consumption, noted to excessively consume alcohol or been arrested for any reason?

PHYSICIAN NAME AND ADDRESS: \_\_\_\_\_

MEDICATIONS AND USAGE: \_\_\_\_\_

- ☐ YES ☐ NO Do you want the Automatic Premium Loan Provision?
- ☐ YES ☐ NO Do you have any existing life insurance or annuity contracts?
- ☐ YES ☐ NO Will this cause any other insurance or annuity to be replaced or changed? \_\_\_\_\_ Company Policy #

I 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 this 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 the agent does not have the authority to waive or modify any question or answer. Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Signed In \_\_\_\_\_, \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Signature of Owner \_\_\_\_\_ Signature of Proposed Insured \_\_\_\_\_

