SENIOR DIRECT *MODIFIED* WHOLE LIFE INSURANCE APPLICATION

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 been diagnosed or treated by a medical professional for AIDS (Acquired Immune Deficiency Syndrome), ARC (AIDS Related Complex), or any immune deficiency related disorder (except HIV), or tested positive during a medical examination for life insurance for HIV (Human Immunodeficiency Virus) or for HIV antibodies?

❑ 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 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 or transplant, uncontrolled high blood pressure (or with complications), uncontrolled diabetes (or with complications)?

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 even if I have paid a premium with, prior to the approval of, this application, I have not purchased immediate insurance coverage. I understand that the insurance applied for shall not go into effect until the first premium is honored by the bank, the application is approved for the class of risk and amount applied for, and the policy is issued, and only then if the Proposed Insured's health condition remains as described in the application at the time. If any of the above conditions are not met, the liability of the Company shall be limited to the return of any amount paid. Pursuant to the requirements of California Insurance Code §10115, the Company limits the amount for which it may be liable prior to the actual issuance and delivery of a life insurance policy to a maximum of fifty thousand dollars ($50,000) (including life insurance and accidental death benefits). 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 _____

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

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: _____/_____/_____

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

X _____
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: _____