## SENIOR DIRECT STANDARD WHOLE LIFE INSURANCE APPLICATION

## **SENIOR LIFE INSURANCE COMPANY**



PO Box 2447 • Thomasville, GA 31799 • 1-877-777-8808

Proposed Insured	1			SSN		/	/	
Address	Street							
						•		
Date of Birth		Age	Gender 🗖 Mal	e 🖵 Female	Height		Weight	
Policy Owner Nar	me			SSN		_/	/	
Relationship to P	Proposed Insured		Hom	ie Telephone (	)_			
Owner's Email A	ddress							
Secondary Addre	ss d) Street	Apt. #	City		State	Zip		
					State	Ζip		
Primary Beneficia	nry NameFirst	Mido	lle	Last	I	Relationshi	ip	
Secondary Benefi	iciary Name		lle					
						Relationshi	1	
☐ YES ☐ NO	ADB Rider \$	Amoun	t of Insurance \$ _		Pre	emium \$		
	ER THESE HEALTH QUEST							
☐ YES ☐ NO	Are you currently hospitalized, or have you been hospitalized	confined to a nursin two or more times i	g facility, receiving henry the past six month	ospice care, una ns, do you expe	lble to care for ct to be admit	yourself, ted to a l	terminally ill, incarcerated nospital 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	In the past six months, have	you experienced an	y unexplained weig	ht loss or weig	ht 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 alcoho consumption, noted to excessively consume alcohol or been arrested for any reason?							
PHYSICIAN NA	AME AND ADDRESS:							
MEDICATIONS	S AND USAGE:							
☐ YES ☐ NO	Do you want the Automatic	Premium Loan Pro	vision?					
☐ 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?							
with, prior to the ap until the first prem Proposed Insured's be limited to the re be liable prior to the death benefits). I a have the authority an application for it any fact material the	l questions and answers, and I affi oproval of, this application, I have r ium is honored by the bank, the a shealth condition remains as descr turn of any amount paid. Pursual he actual issuance and delivery of a lso understand that Senior Life In- to waive or modify any question of insurance or statement of claim contereto commits a fraudulent insura	rm that they are true not purchased immed pplication is approve ibed in the application at to the requirement life insurance policy surance Company wi r answer. Any person ontaining any materiance act, which is a cr	to the best of my knot liate insurance covera d for the class of risk a on at the time. If any o es of California Insura to a maximum of fift Il rely on my answers in who knowingly and ally false information ime and subjects such	owledge and belge. I understand and amount apport the above conduce Code §101 thousand dollar above in issuing with intent to dor conceals, for a person to crim	ief. I understa: I that the insur- blied for, and the ditions are not 15, the Compa ars (\$50,000) (i any life insural defraud any insural the purpose o inal and civil p	nd that evance appliance policy is met, the land limits including ince hereus surance confirmiteleading benalties.	ied for shall not go into effect s issued, and only then if the iability of the Company shall the amount for which it may life insurance and accidental nder, and the agent does not ompany or other person files	
orgined in		·····	Date		······································			
Signature of Owne SDSTD10_05	er		Signature of Pro	posed Insured .			CA	

Payment Type	Paym	ent Mode	Due Date			
□BSP □DB □IW □DC	☐ Monthly ☐ Quarterly	□ Semi-Annual □ Annual	□ 1 <sup>st</sup> □ 3 <sup>rd</sup> □ 5 <sup>th</sup> □ 10 <sup>th</sup> □ 15 <sup>th</sup> □ 20 <sup>th</sup> □ 25 <sup>th</sup>			
	my bank/financial institution or de		yments for this insurance by electronic or other means eorgia. If said account is replaced by another account.			
this request and authorization shall a respect to it, will be the same as if it v	apply as well. I agree that Senion were signed or initiated personall ander any liability even though dish	r Life Insurance Company's treatm y by me. I also agree that if any ch nonor results in forfeiture of insuran	nent of each check or ACH debit, and their rights with eck or ACH debit is dishonored for any reason, Senio ce. I understand this authorization is to remain in effec			
unui enner Senior Life insurance Con	ipany of i cancer by sending the	other party a writter request to do	50.			
☐ Checking ☐ Savings		Initial With	drawal Date// (or as soon as possible thereafter)			
Name(s) on Account:			(or as soon as possible increasely			
Bank/Financial Institution Name:						
Name of Bank Employee verifying sav	vings information:	Routing Number (9 digits):				
Address:			State: Zip:			
Phone: ()		,				
☐ Visa ☐ MasterCard						
Name on Card:						
Traine on ourd.			_			
Debit Card Account Number:			Expiration Date:/			
X			(3 - Digit Security Code located on back of card			
Signature of Payor						
STATEMENT OF INSURABLE IN	ITEREST - Complete if insur	ring any person other than se	If and/or spouse.			
☐ YES ☐ NO Do you have insu	rable interest in the person to be	e insured?				
☐ YES ☐ NO Do you have com	plete knowledge of the health hi	story of the person to be insured?				
☐ YES ☐ NO If you are insuring	YES NO If you are insuring grandchildren, are all such dependents being insured, and are you responsible for their financial support?					
If no, please expl	ain:					
The Proposed Insured is my:  Pare						
Best time to reach Proposed Insured						
My insurable interest in the Proposed						
☐ The Proposed Insured is legally	indebted to me in an amount not	less than the face amount of the p	olicy applied for.			
AGENT STATEMENT						
Are there any existing life insurance of	•	•				
	of my knowledge, replacement	•	te and that I have accurately recorded the answers ansaction. When required by the laws of the state, I			
Agent's Signature:		Agent Numb	er:			
		License Nun	nber:			
SDSTD10_05			C/			