# SENIOR DIRECT *MODIFIED* WHOLE LIFE INSURANCE APPLICATION

❑ Modified (Ages 40-75)
❑ Graded (Ages 76-85)

## 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 ( ) _____

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 exposure to the HIV Infection or been diagnosed as having ARC or AIDS caused by the HIV 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 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 & 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 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. I further acknowledge that any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information may be guilty of a felony of the third degree.

Signed In _____, _____ Date _____ Time _____

Signature of Owner_____ Signature of Proposed Insured _____

| | MODIFIED-NATURAL DEATH | ADB | | GRADED-DEATH BENEFIT |
|---|---|---|---|---|
| FIRST YEAR | 110% of premiums paid | Face Amount | FIRST YEAR | 50% of Face Amount |
| SECOND YEAR | 110% of premiums paid | Face Amount | SECOND YEAR | 75% of Face Amount |
| THIRD YEAR | Face Amount | Face Amount | THEREAFTER | Face Amount |

| 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**

I certify that each question in all parts of the application were 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.

Agent's Signature: _____ Agent Number: _____

Printed Name: _____ License Number: _____