SENIOR DIRECT *ULTIMATE PREFERRED* WHOLE LIFE INSURANCE APPLICATION

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

SENIOR LIFE INSURANCE COMPANY®

Policyowner/Proposed Insured: _____ SSN: ___/___/___
Herein referred to as "you"

Address: _____
Street Apt.# City State Zip

Date of Birth: _____ Age: _____ Gender: ❑ Male ❑ Female Height: _____ Weight: _____

Policyowner/Proposed Insured's Email Address: _____ Phone: (_____) _____

Secondary Address: _____
(If different from Insured's) 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, legally blind, wheelchair bound, or bedridden; in the past ten years, have you been hospitalized two or more times or received home health care; 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 In the past twelve months, have you experienced any unexplained weight loss or weight gain?

❑ YES ❑ NO In the past ten years, have you used any form of tobacco or nicotine product or had a blood pressure reading over 135/85?

❑ YES ❑ NO In the past ten years, have you been advised or recommended to have any tests, treatment, 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 ten years, have you had, been treated for, received medical advice or been prescribed medication for, or been diagnosed with diabetes; high blood pressure; stroke; paralysis; cancer; any heart, organ, or lung disease (including COPD (Chronic Obstructive Pulmonary Disease)/emphysema); mental disorder/retardation; disorder of the brain or nervous system; or any impairment, disorder, disease, transplant, or chronic illness?

❑ YES ❑ NO Have you used illegal drugs, been treated for drug/alcohol abuse, been advised by a physician to reduce alcohol consumption, been 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 policies or annuity contracts?

❑ YES ❑ NO Do you intend to replace, discontinue, or change any existing life insurance policies or annuity contracts in connection with this application? If yes, list Company and Policy No. _____

_____

THIS SECTION AFFECTS YOUR LEGAL RIGHTS

1. THE POLICY FOR WHICH YOU ARE APPLYING INCLUDES A BINDING ARBITRATION AGREEMENT.
2. THE ARBITRATION AGREEMENT REQUIRES THAT ANY DISPUTE 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, ONE OR MORE ARBITRATORS, WHO ARE INDEPENDENT, NEUTRAL DECISION MAKERS, RENDER A DECISION AFTER HEARING THE POSITIONS OF THE PARTIES.
5. WHEN YOU ACCEPT THIS INSURANCE POLICY YOU AGREE TO RESOLVE ANY DISPUTE RELATED TO THE POLICY BY BINDING ARBITRATION INSTEAD OF A TRIAL IN COURT, INCLUDING A TRIAL BY JURY.
6. BINDING ARBITRATION GENERALLY TAKES THE PLACE OF RESOLVING DISPUTES BY A JUDGE AND JURY.
7. SHOULD YOU NEED ADDITIONAL INFORMATION REGARDING THE BINDING ARBITRATION PROVISION IN THE POLICY, YOU MAY CONTACT OUR TOLL-FREE ASSISTANCE LINE AT 1-877-777-8808.
8. YOU WILL HAVE FIVE (5) DAYS FROM AND AFTER DELIVERY OF THE POLICY TO REJECT THE POLICY IF YOU DO NOT WANT TO ACCEPT THE REQUIREMENT FOR ARBITRATION.

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. I understand that this same type of insurance may be available through an insurance company that does not require that policy related disputes be resolved by binding arbitration.

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 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 that the agent does not have the authority to waive or modify any question or answer. Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

Signed In:_____ Date:_____ Time:_____

Signature of Policyowner/Proposed Insured: _____

Payment Type	Payment Mode	Due Date
❑ BSP (Checking) ❑ IW	❑ 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 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 (Automated Clearing House) 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 (Automated Clearing House) 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.

Name(s) on Account: _____

Bank/Financial Institution Name: _____

Routing Number (9 digits): _____ Bank Account Number: _____

X_____ Initial Withdrawal Date: ____/____/____
Signature or as soon as possible thereafter

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: _____