APPLICATION FOR TERM LIFE INSURANCE

Underwritten by Senior Life Insurance Company, Thomasville, GA

Proposed Insured Name (Herein referred to as "you")	**Male** ☐ **Female** ☐	**Date of Birth** / /	**Premium** $	
Plan: ☐**Term 20:** Face amount $ _____ ☐**Term 20 ROP:** ☐$10,000 ☐$20,000 ☐$30,000 ☐$40,000 ☐$50,000		**SSN** / /	**Height**	**Weight**

Address _____ Apt. _____

City _____ State _____ Zip _____

Telephone (_____) _____ Email _____

Beneficiary Name	**Relationship to Proposed Insured**

Please answer the following questions or provide information where indicated:	**YES**	**NO**
1. Have you used any form of tobacco or nicotine product in the past twelve months?	❑	❑
2. Are you currently hospitalized, confined to a nursing facility, receiving hospice or home health care, unable to care for yourself, terminally ill, or incarcerated; have you been hospitalized two or more times in the past three years; or do you expect to be admitted to a hospital or nursing facility in the next twelve months?	❑	❑
3. 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?	❑	❑
4. In the past five years, have you been advised or recommended to have any test, procedure, surgery, or hospitalization which has not been received or completed, or been advised to take medications and have not been compliant?	❑	❑
5. In the past five years, have you used any illegal drugs or excessively used drugs or alcohol, or have you been treated for or advised to have treatment for drug or alcohol abuse?	❑	❑
6. In the past five years, have you had, received medical advice for, or been treated for, diagnosed with, or prescribed medication for any of the following:		
A. Cancer; stroke; coronary artery disease; any lung disease, including COPD (Chronic Obstructive Pulmonary Disease)/emphysema; or any disease or disorder of the heart, brain, liver, or circulatory system?	❑	❑
B. Chronic kidney disease or kidney failure; muscular disease; mental disorder; seizure disorder; uncontrolled high blood pressure; or uncontrolled diabetes, including any complications from such?	❑	❑
C. Disorder of the nervous system or any impairment, disorder, disease, transplant, or chronic illness?	❑	❑
7. A. Please provide your physician's name and location: _____		
B. Have you taken any medications in the past five years? If yes, please list their names and usage, including any medications you are currently taking: _____	❑	❑
8. Do you have any existing life insurance policies or annuity contracts?	❑	❑
9. 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. _____	❑	❑

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.

Sign Here X _____ / / _____ Signed In _____

(Signature of Proposed Insured) **(Date)** **(City, State)**

Payment Type	Payment Mode	Due Date
❑ Bank Service Plan ❑ Direct Bill ❑ Initial Withdrawal ❑ Debit Card	❑ 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 (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.

❑ 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: _____/_____/_____

X _____ ☐☐☐ (3 - Digit Security Code located on back of card)
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 policies 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: _____