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 by a physician or other licensed health practitioner to excessively consume alcohol, or been convicted of a felony or misdemeanor?

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. _____

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 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

Authorization for Release of Health Information

This Authorization complies with the HIPAA Privacy Rule

I hereby authorize any health plan, physician, health care professional, hospital, clinic, laboratory, pharmacy, pharmacy benefit manager, medical facility, insurance company, insurance support organization (such as Medical Information Bureau, Inc.), or other health care provider that has provided payment, treatment, or services to me or on my behalf ("My Providers") to disclose my entire medical record and any other protected health information concerning me to Senior Life Insurance Company (the "Company") and its agents, employees, and representatives. This includes information on the diagnosis or treatment of HIV (Human Immunodeficiency Virus), AIDS (Acquired Immune Deficiency Syndrome), and sexually transmitted diseases and includes information on the diagnosis and treatment of mental illness and the use of alcohol, drugs, and tobacco, but excludes psychotherapy notes.

I acknowledge that any agreements I have made to restrict my protected health information do not apply to this Authorization, and I instruct My Providers to release and disclose the entire medical records without restrictions.

This protected health information is to be disclosed under this Authorization so that the Company may:

1) underwrite my application for coverage and make eligibility, risk rating, policy issuance, and enrollment determinations;
2) obtain reinsurance;
3) administer claims and determine or fulfill responsibility for coverage and provision of benefits;
4) administer coverage; and
5) conduct other legally permissible activities that relate to any coverage I have or have applied for with the Company.

I understand that this Authorization shall remain in force for 24 months following the date of my signature below and that a copy of this Authorization is as valid as the original. I understand that I have the right to revoke this Authorization in writing, at any time, by sending a written request for revocation to the Company, Attention: HIPAA Privacy Official, P.O. Box 2447, Thomasville, GA 31799-2447. I understand that a revocation is not effective to the extent that any of My Providers has relied on this Authorization or to the extent that this Authorization was provided as a condition of obtaining insurance coverage and the extent that other law provides the Company with the right to contest a claim for coverage under the policy or to contest the policy itself. I understand that any information disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal regulations governing privacy and confidentiality of health information. However, the Company will protect the privacy of health information in accordance with other applicable state and/or federal privacy laws and in accordance with the Company's own privacy policy.

I understand that My Providers may not refuse to provide treatment or payment for health care services if I refuse to sign this Authorization. I further understand that if I refuse to sign this Authorization to release my complete medical records, the Company may not be able to process my application, or if coverage has been issued, may not be able to process policy claims and/or make any benefit payments. I am entitled to receive a copy of this Authorization. My Personal Representative is also entitled to receive a copy of this Authorization.

_____
Policyowner/Proposed Insured's Printed Name

_____ _____
Policyowner/Proposed Insured's Signature Date

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: _____