## SENIOR DIRECT 20 PAY STANDARD WHOLE LIFE INSURANCE APPLICATION



## **SENIOR LIFE INSURANCE COMPANY**

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

Proposed Insure	d					22N	/	/	
Address									
				□ F1.		State	<b>XV</b> 1. 1. 1.	Zip	
Date of Birth		Age	Gender 🗖 Male	☐ Female	Height _		Weigh	nt	
Policy Owner Na	nme					SSN	/	/	
Relationship to I	Proposed Insured		Home Telephone (			)			
Secondary Addre (If different than Insure	ess d) Street	Apt. #		City		State	Zip		
Primary Benefici	ary NameFirst		Middle	Last		D -1-	tionship		
	ficiary Name		Middle	Last		Reia	tionsmp		
occondary benef	First		Middle	Last		Rela	tionship		
☐ YES ☐ NO	ADB Rider \$	A	mount of Insuranc	e \$			Premium \$		
PLEASE ANSW	ER THESE HEALTH	I QUESTIONS (M	ust answer "NO" to	o 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	In the past six months, have you experienced any unexplained weight loss or weight 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 alcohol consumption, noted to excessively consume alcohol or been arrested for any reason?								
PHYSICIAN NA	AME AND ADDRES	SS:							
MEDICATIONS	S & USAGE:								
	Do you want the Au								
☐ YES ☐ NO	Do you have any existing life insurance or annuity contracts?								
☐ YES ☐ NO	Will this cause any o	ther insurance or a	nnuity to be replace	ed or changed?				D-1:#	
					Comp	any		Policy #	
insurance to go in is honored by the any life insurance knowingly, and wi	all questions and ansato effect, the Proposed bank and the policy is hereunder, and the age ith intent to injure, defination may be guilty of a	l Insured's health co issued. I also unders ent does not have the raud or deceive any in	ndition must remai tand that Senior Lif authority to waive o	n as described in Te Insurance Co rr modify any qu	n the appl mpany wi estion or a	ication at ll rely on r nswer. W	the time th ny answers ARNING:	he first premium above in issuing Any person who	
Signed In		,	Date			Time	e		
Signature of Owne	r		Signature of	Proposed Insure	ed				

STDWL0720\_37

Payment Type	Payment Mode	Due Date						
□BSP □DB □IW □CC	☐ Monthly ☐ Quarterly ☐ Semi-Annual	□ Annual	☐ 1 <sup>st</sup> ☐ 5 <sup>th</sup> ☐ 10 <sup>th</sup> ☐ 15 <sup>th</sup> ☐ 20 <sup>th</sup> ☐ 25 <sup>th</sup>					
means directly from my account iden another account, this request and auth their rights with respect to it, will be the any reason, Senior Life Insurance Com	my bank/financial institution or credit card issuer tified below and payable to Senior Life Insurandorization shall apply as well. I agree that Senior Les same as if it were signed or initiated personally	ce Company, The fe Insurance Co by me. I also ag nonor results in t	e payments for this insurance by electronic or other nomasville, Georgia. If said account is replaced by ompany's treatment of each check or ACH debit, and gree that if any check or ACH debit is dishonored for forfeiture of insurance. I understand this authorization a written request to do so					
☐ Checking ☐ Savings	The modification company of Foundarity contains		rawal Date/					
Name(s) on Account:			(or as soon as possible increance)					
Bank/Financial Institution Name:								
Name of Bank Employee verifying sav	rings information: Routing Number (S	digits):						
	Bank Account # _							
Address:	City:		State: Zip:					
Phone: ()	·····							
Name on Card: Credit Card Account Number: X Signature			Expiration Date:/					
<b>3</b>	REST - Complete if insuring any person other t	han self and/or	cholica					
	able interest in the person to be insured?	nan sen anaroi	cpouds.					
•	lete knowledge of the health history of the persor	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  The Proposed Insured is legally in	nsured s life is as follows: ndebted to me in an amount not less than the fac	e amount of the	policy applied for.					
I certify that each question in all parts o	annuity contracts on the life of the proposed insuftence of the application were asked and the answers are ny knowledge, replacement  is is is not involved.	true and comple	ete and that I have accurately recorded the answers in					
Agent's Signature:		Agent Numb	er:					
Printed Name:		License Nur	nber:					