

APPLICATION FOR TERM LIFE INSURANCE

Underwritten by Senior Life Insurance Company, Thomasville, GA

Proposed Insured Name (Herein referred to as "you")	Male <input type="checkbox"/>	Female <input type="checkbox"/>	Date of Birth / /	Premium \$
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Plan: <input type="checkbox"/> Term 20: Face amount \$	SSN / /	Height / Weight /
<input type="checkbox"/> Term 20 ROP: <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> \$30,000 <input type="checkbox"/> \$40,000 <input type="checkbox"/> \$50,000		
<input type="checkbox"/> Modified Term 10: Face Amount \$		

Address	Street	Apt. #	City	State	Zip
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Telephone ()	Email
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Beneficiary Name	Relationship to Proposed Insured
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Please answer these health questions:

YES NO

Part 1: Uninsurable Questions: If the answer to any question in Part 1 is "Yes," you are not eligible for coverage. Must answer "No" to qualify.

1. Are you currently hospitalized, confined to a nursing facility, receiving hospice or home health care, unable to care for yourself, terminally ill, or incarcerated; or do you expect to be admitted to a hospital or nursing facility in the next twelve months?..... ☐ ☐
2. 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?..... ☐ ☐

Part 2: If the answer to any question in Part 2 is "Yes," you may be eligible for the Modified Term 10 plan with a death benefit of 110% of premiums paid in the first year and 120% of premiums paid in the second year. If "No," you may be eligible for the Term 20 plan or Term 20 ROP plan.

3. Have you been hospitalized two or more times in the past three years? ☐ ☐
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 have you been advised to take medications and have not been compliant?..... ☐ ☐
5. In the past five years, have you used illegal drugs, been noted by a physician or other licensed health practitioner to excessively consume alcohol, or have you been treated for or advised by a physician or other licensed health practitioner 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? ☐ ☐

Please answer the following questions or provide information where indicated:

7. Have you used any form of tobacco or nicotine product in the past twelve months? ☐ ☐
8. Please provide your physician's name and location:
9. 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: ☐ ☐
10. Do you have any existing life insurance policies or annuity contracts? ☐ ☐
11. Will issuance of this policy cause any other existing life insurance policies or annuity contracts to be replaced or changed? 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. I understand that any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

Sign Here **X** _____ / ____ / ____ Signed In _____
(Signature of Proposed Insured) (Date) (City, State)

Payment Type	Payment Mode	Due Date
<input type="checkbox"/> BSP <input type="checkbox"/> IW	<input type="checkbox"/> Monthly <input type="checkbox"/> Quarterly <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Annual	<input type="checkbox"/> 1 st <input type="checkbox"/> 3 rd <input type="checkbox"/> 5 th <input type="checkbox"/> 10 th <input type="checkbox"/> 15 th <input type="checkbox"/> 20 th <input type="checkbox"/> 25 th

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.

☐ **Checking** 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: _____

X _____ Phone: (_____) _____

Signature of Payor

AGENT STATEMENT

Are there any existing life insurance policy 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: _____