SENIOR LIFE
INSURANCE COMPANY

APPLICATION FOR ULTIMATE PREFERRED WHOLE LIFE INSURANCE

Executive Office:
1 Senior Life Lane
Thomasville, GA 31792

OWNER INFORMATION

Name:	**SSN:**	**Relationship to Insured:**	
Email:	**Phone:**	**Cell Phone:**	
Address:	**City:**	**State:**	**Zip:**

INSURED INFORMATION - *All applicants must permanently reside in the United States.*

Name:	**Phone:**	**Age:**		
Address:	**City:**	**State:**	**Zip:**	
SSN:	**Date of Birth:**	**Sex:**	**Ht:**	**Wt:**

BENEFICIARY INFORMATION

Primary:	**Relationship:**	**Phone:**	
Address:	**City:**	**State:**	**Zip:**
Contingent:	**Relationship:**	**Phone:**	
Address:	**City:**	**State:**	**Zip:**

PLAN INFORMATION

❑ YES ❑ NO **ADB Rider: $** **Amount of Insurance: $** **Premium: $**

HEALTH QUESTIONS

PLEASE ANSWER THE FOLLOWING QUESTIONS:

1. Are you currently hospitalized, confined to a nursing facility, receiving hospice care, unable to care for yourself, terminally ill, incarcerated, legally blind, wheelchair bound, bedridden, or do you expect to be admitted to a hospital or nursing facility? ..... **❑ YES ❑ NO**
2. Have you tested positive for exposure to the Human Immunodeficiency Virus (HIV) Infection or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)?..... **❑ YES ❑ NO**
3. In the past twelve months, have you experienced any unexplained weight loss or weight gain? ..... **❑ YES ❑ NO**
4. 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**
5. In the past ten years, have you been hospitalized two or more times or received home health care?..... **❑ YES ❑ NO**
6. 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**
7. 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**
8. In the past ten years, 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 or incarcerated for any reason?..... **❑ YES ❑ NO**

Physician Name and Address: _____

Medications and Usage:

AUTOMATIC PREMIUM LOAN

Do you want the Automatic Premium Loan Provision? ..... **❑ YES ❑ NO**

REPLACEMENT

1. **Does the applicant have existing life insurance or annuity contracts?** ..... **❑ YES ❑ NO**
2. **Will this policy replace or change other insurance or annuities?** ..... **❑ YES ❑ NO**

If "yes", list Company and Policy No.

THIRD PARTY NOTIFICATION

If you would like to provide copies of notices concerning lapse or cancellation for non-payment of premium to a third party please provide their

Address:	**City:**	**State:**	**Zip:**

ARBITRATION

1. THE POLICY FOR WHICH YOU ARE APPLYING INCLUDES A BINDING ARBITRATION AGREEMENT. 2. THE ARBITRATION AGREEMENT REQUIRES THAT ANY DISAGREEMENT 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 THE INSURED AND THE INSURANCE COMPANY. 4. IN AN ARBITRATION, AN ARBITRATOR, WHO IS AN INDEPENDENT, NEUTRAL PARTY, GIVES A DECISION AFTER HEARING THE POSITIONS OF THE PARTIES. 5. WHEN THE INSURED ACCEPTS THE INSURANCE POLICY THE INSURED AGREES TO RESOLVE ANY DISAGREEMENT RELATED TO THE POLICY BY BINDING ARBITRATION INSTEAD OF A TRIAL IN COURT INCLUDING A TRIAL BY JURY. 6. ARBITRATION TAKES THE PLACE OF RESOLVING DISPUTES BY A JUDGE AND JURY AND THE DECISION OF THE ARBITRATOR CANNOT BE REVIEWED IN COURT BY A JUDGE AND JURY.

HIPAA AUTHORIZATION FOR DISCLOSURE OF MEDICAL INFORMATION TO SENIOR LIFE INSURANCE COMPANY

I authorize any health care provider, plan, or clearinghouse, insurance company, pharmacy, pharmacy benefit manager, Medicare or Medicaid agencies or the Medical Information Bureau, or Consumer Reporting Agency to disclose to Senior Life all your medical records, and including information on medical consultations, treatments, surgeries, or hospital confinements for physical and mental conditions, use of drugs, alcohol, or tobacco, prescription drugs, communicable disease such as HIV or AIDS, but excludes psychotherapy notes. This information will be used by Senior Life to determine eligibility for insurance and administer coverage. Other entities to which this information may be disclosed may not be covered by federal privacy rules and if this information is re-disclosed, it may no longer be protected by those rules. This authorization will be valid for thirty months from the date the authorization is signed. A copy of this authorization shall be as valid as the original. You are entitled to receive a copy of this authorization. You may revoke this authorization at any time by sending written notice to Senior Life, but any action taken in reliance on this authorization cannot be reversed. By verbally or physically signing this Application I hereby sign and agree to the HIPAA authorization.

ACKNOWLEDGMENT OF APPLICATION

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 or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison, or any combination thereof.

BANKING AUTHORIZATION

I authorize, until I revoke in writing, my bank/financial institution to deduct future payments for this insurance by electronic or other means directly from my account identified below. If I provide a check as an initial premium payment, I authorize the Company to either use information from my check to make a one-time electronic fund transfer from my account or to process the payment as a check transaction. I understand funds may be withdrawn from my account as soon as the same day and my check will not be returned by my financial institution.

❑ Checking ❑ Savings Draft Date: ❑ 1st, ❑ 3rd, ❑ 5th, ❑ 10th, ❑ 15th, ❑ 20th, ❑ 25th

❑ Initial Withdrawal Date _____ or as soon as possible thereafter

❑ Monthly EFT ❑ Semi-Annual ❑ Annual ❑ Quarterly

Routing Number (9 digits)

Financial Institution Name

Account Number

Names on Account or Card

❑ Visa ❑ Master Card

#1 _____

#2 _____

Credit Card Account Number

/

Exp. Date

OWNER, INSURED, & PAYOR MUST SIGN BELOW

Owner, Insured, and Payor must sign here *Signed In City, State* *Date*

AGENT'S CONFIRMATION

Are there existing life insurance and/or annuity contracts on the life of the applicant ?..... ❑ Yes ❑ No

If replacement is involved or otherwise required, I presented and read the applicant a notice regarding replacement.

Signature of Agent *Printed Name* *Agent's Number*