SENIOR LIFE
INSURANCE COMPANY

APPLICATION FOR
MODIFIED WHOLE LIFE INSURANCE

Executive Office:
1 Senior Life Lane
Thomasville, GA 31792

POLICYOWNER 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

Face Amount:

RIDER INFORMATION

Accidental Death	❑YES ❑NO	Charitable Benefit	❑YES ❑NO
Child	❑YES ❑NO		

Base Plan Premium:

Rider Premiums:

Total Premium:

HEALTH QUESTIONS

PLEASE ANSWER THE FOLLOWING QUESTIONS.

1. Are you currently hospitalized; confined to a nursing facility; receiving hospice care; receiving home health care; unable to care for yourself; terminally ill; legally blind; wheelchair bound; bedridden; on oxygen; incarcerated; or do you expect to be admitted to a hospital or nursing facility? ..... **❑YES ❑NO**
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 Infection or other sickness or condition derived from such infection? ..... **❑YES ❑NO**
3. In the past six months, have you been hospitalized two or more times? ..... **❑YES ❑NO**
4. In the past two years, have you had, been treated for, received medical advice, been prescribed medication for, or been diagnosed by a licensed member of the medical profession with uncontrolled diabetes or uncontrolled high blood pressure, including any complications from such; any heart **AND** any lung disease/condition/disorder; any blood, kidney, or liver disease/condition/disorder; Alzheimer's disease; cancer; cerebral palsy; cystic fibrosis; dementia; Huntington's disease; Lou Gehrig's disease; multiple sclerosis; muscular dystrophy; paralysis; stroke; or transplant? ..... **❑YES ❑NO**
5. In the past two years, have you used illegal drugs, been treated for drug/alcohol abuse, been advised by a physician to reduce alcohol consumption, or been noted to excessively consume alcohol? ..... **❑YES ❑NO**

Physician Name and Address: _____

Medications and Usage *(Excluding treatment for HIV, ARC, or AIDS)*:

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.

FIRST YEAR…110% of premiums paid **SECOND YEAR…110% of premiums paid** **THIRD YEAR…Full Amount of Insurance**

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 the following.

Name: Relationship to Insured:

Address: City: State: Zip:

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

I authorize any health care provider, pharmacy, pharmacy benefit manager, the MIB Group Inc., or Consumer Reporting Agency to disclose to Senior Life or its representatives all my medical records and/or prescription history. 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 twenty-four (24) 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. Any action taken in reliance on this authorization cannot be reversed. By verbally or physically signing this Application I hereby sign and agree to this authorization.

ACKNOWLEDGMENT OF APPLICATION

I have read or have been read all questions and answers. 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 will rely on my answers above in issuing any life insurance. The agent does not have the authority to waive or modify any question or answer. **Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.**

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.

Initial Withdrawal Date: _____ or as soon as possible thereafter Draft Day: _____

Names on Account: _____ Payment Mode: ❑ Monthly ❑ Semi-Annual ❑ Annual

❑ Checking ❑ Savings Financial Institution Name: _____

Routing Number (9 digits): _____ Account Number: _____

Credit Card Number: _____ Expiration Date: _____ CVV Code: _____

POLICYOWNER, INSURED, & PAYOR MUST SIGN HERE

_____ _____ _____

Policyowner's Signature City, State Signed In Date

_____

Insured's Signature

_____

Payor's Signature

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.

_____ _____ _____

Agent's Signature Printed Name Agent's License Number