## SENIOR DIRECT MODIFIED WHOLE LIFE INSURANCE APPLICATION



## SENIOR LIFE INSURANCE COMPANY PO Box 2447 • Thomasville, GA 31799 • 1-877-777-8808

Proposed Insured					SSN	//				
Address	Street									
			City		State	Zip				
Date of Birth		Age Ge	ender 🗖 Male 🗖	Female I	Height	Weight _				
Policy Owner Nan	ne				SSN	/				
Relationship to Pr	roposed Insured	Home Tel	ephone (	)						
Secondary Addres	Street	Apt. #	City		State	Zip				
Primary Beneficia	rv Name									
Timar, Benerica	ry NameFirst	M	iddle	Last	Rela	ationship				
Secondary Benefic	ciary NameFirst									
,	First	M	liddle	Last	Rela	ationship				
☐ YES ☐ NO	ADB Rider \$	Amou	unt of Insurance \$ _		Prem	nium \$				
PLEASE ANSWE	ER THESE HEALTH	QUESTIONS (Must a	nswer "NO" to qua	lify):						
☐ 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?  Have you tested positive for 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	Are you legally blind, wheelchair bound, bedridden, on oxygen, or receiving home health care?									
☐ YES ☐ NO	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 noted to excessively consume alcohol?									
☐ YES ☐ NO		have you had, been tr ication for, or been di					oner,			
	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, uncontrolled high blood pressure (or with complications), uncontrolled diabetes (or with complications)?  ME AND ADDRESS:									
PHYSICIAN NA	ME AND ADDRESS:									
MEDICATIONS	& USAGE:									
☐ YES ☐ NO	Do you want the Auto	matic Premium Loan l	Provision?							
	Do you have any existi									
☐ YES ☐ NO	Will this cause any other insurance or annuity to be replaced or changed? Company Policy #									
I have been read al ance to go into eff honored by the ba any life insurance that any person wh	ll questions and answer ect, the Proposed Insur nk and the policy is issu hereunder, and the ag o knowingly and with ir r misleading informatio	s and I affirm that they red's health condition led. I also understand ent does not have the tent to injure, defraud o	are true to the best of must remain as descri that Senior Life Insu authority to waive of or deceive any insurer	of my knowledg ribed in the ap rance Compar r modify any q files a statemer	ge and belief. plication at th ny will rely on n uestion or ans	I understand the time the first my answers abo	nat for insur- premium is ve in issuing acknowledge			
Signed In			Date		Tim	e				
			Signature of Proposed Insured							

Payment Type □ BSP □ DB □ IW □ CC	☐ Monthly	Payme Quarterly	ent Mode  Semi-Annual	□ Annual	<b>□1</b> st	□5 <sup>th</sup>	Due □10 <sup>th</sup>	Date □15 <sup>th</sup>	□20 <sup>th</sup>	<b>□</b> 25 <sup>th</sup>
BANK SERVICE PLAN AUTHORIZA As a convenience to me, I authorize to means directly from my account identifi account, this request and authorizatio rights with respect to it, will be the sar reason, Senior Life Insurance Comparis to remain in effect until either Senior	my bank/financia ied below and pa n shall apply as ne as if it were s ny will not be und	ayable to Senio well. I agree the igned or initiated der any liability	r Life Insurance Cor nat Senior Life Insur ed personally by me even though dishor	mpany, Thomas rance Compan e. I also agree nor results in fo	sville, Geor y's treatme that if any rfeiture of	gia. If sent of each check of insuran	aid accor ach chec or ACH d ce. I und	unt is rep k or ACH ebit is dis	laced by I debit, a shonored	another nd their for any
☐ Checking ☐ Savings Initial Withdrawal Date// (or as soon as possible there										
Name(s) on Account:						(or	as soon	as possibl	e thereaft	er)
Bank/Financial Institution Name:										
Name of Bank Employee verifying sav	rings information	:	Routing Number (9 digits):							
			Bank Account #							
Address:	· · · · · · · · · · · · · · · · · · ·									
Phone: ()			-							
	EST - Complete able interest in tolete knowledge grandchildren, a	if insuring any phe person to be of the health hings all such dep	person other than see insured? story of the person endents being insured.	to be insured? red, and are yo	se.	ible for	their fina	/ ncial sup		
The Proposed Insured is my: ☐ Parer Best time to reach Proposed Insured b My insurable interest in the Proposed ☐ The Proposed Insured is legally i	y phone: Insured's life is a	as follows:				lied for.				
AGENT STATEMENT I certify that each question in all parts of the application were 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 $\Box$ is $\Box$ is not involved in this transaction.										
Agent's Signature:				Agent Numb	oer:					
Printed Name:		License Number:								