



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

Proposed Insured \_\_\_\_\_ SSN \_\_\_\_/\_\_\_\_/\_\_\_\_

Address \_\_\_\_\_  
Street Apt. # City State Zip

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Gender  Male  Female Height \_\_\_\_\_ Weight \_\_\_\_\_

Policy Owner Name \_\_\_\_\_ SSN \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship to Proposed Insured \_\_\_\_\_ Home Telephone ( ) \_\_\_\_\_

Secondary Addressee \_\_\_\_\_  
(For past due premium notices) Street Apt. # City State Zip

Primary Beneficiary Name \_\_\_\_\_  
First Middle Last Relationship

Secondary Beneficiary Name \_\_\_\_\_  
First Middle Last Relationship

YES  NO ADB Rider \$ \_\_\_\_\_ Amount of Insurance \$ \_\_\_\_\_ Premium \$ \_\_\_\_\_

**PLEASE ANSWER THESE HEALTH QUESTIONS (Must answer "NO" to 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 been treated, received medical advice or prescribed medication for or been diagnosed by a licensed medical practitioner 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 by a licensed medical practitioner 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 NAME AND ADDRESS:** \_\_\_\_\_

**MEDICATIONS & USAGE:** \_\_\_\_\_

- YES  NO Do you want the Automatic Premium Loan Provision?
- YES  NO Do you have any existing life insurance or annuity contracts?
- YES  NO Will this cause any other insurance or annuity to be replaced or changed? \_\_\_\_\_  
Company Policy #

I 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 the agent does not have the authority to waive or modify any question or answer. I further acknowledge that 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.

Signed In \_\_\_\_\_, \_\_\_\_\_ Date \_\_\_\_\_ Time \_\_\_\_\_

Signature of Owner \_\_\_\_\_ Signature of Proposed Insured \_\_\_\_\_

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

**BANK SERVICE PLAN AUTHORIZATION**

As a convenience to me, I authorize my bank/financial institution or credit card issuer 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 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 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  Savings

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: \_\_\_\_\_

Phone: (\_\_\_\_\_) \_\_\_\_\_

Visa  MasterCard

Name on Card: \_\_\_\_\_

Credit Card Account Number: 

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 Expiration Date: \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_

**X**  
Signature \_\_\_\_\_

**STATEMENT OF INSURABLE INTEREST - Complete if insuring any person other than self and/or spouse.**

- YES  NO Do you have insurable interest in the person to be insured?
- YES  NO Do you have complete knowledge of the health history of the person 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 Insured's life is as follows:

- The Proposed Insured is legally indebted to me in an amount not less than the face amount of the policy applied 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  is  is not involved in this transaction.

Agent's Signature: \_\_\_\_\_ Agent Number: \_\_\_\_\_

Printed Name: \_\_\_\_\_ License Number: \_\_\_\_\_