SENIOR LIFE INSURANCE COMPANY

INSURED INFORMATION

Insured:	Email:	Phone:	
Address:	City:	State:	Zip:
SSN:	Gender: ❑ Male ❑ Female	DOB:	Age:

POLICYOWNER INFORMATION IF DIFFERENT THAN INSURED

Policyowner:	Relationship:	Phone:	
Address:	City:	State:	Zip:

FOR PAST DUE PREMIUM NOTICES

Secondary Address:	City:	State:	Zip

BENEFICIARY INFORMATION

Primary Beneficiary:	Relationship:	City:	Ph:
Contingent Beneficiary:	Relationship:	City:	Ph:

PLAN INFORMATION

Amount of insurance $	Accidental Death Benefit $	Monthly Premium $

GUARANTEED ISSUE - NO HEALTH INFORMATION REQUIRED

FIRST THREE YEARS - 110% OF PREMIUMS PAID FOURTH YEAR - FULL FACE AMOUNT

REPLACEMENT

Is this insurance intended to replace or change any existing life insurance or annuity plan? ..... ❑ Yes ❑ No

If yes, list Company and Policy Number _____

AUTOMATIC PREMIUM LOAN

Check here if policyowner does NOT want the Automatic Premium Loan Provision..... ❑

AUTHORIZATION

I authorize any physician, medical practitioner, hospital, medical care facility, Veteran's Administration, pharmacy, pharmacy benefit manager, laboratory, or any other medically-related person or facility to furnish any health and/or treatment information about the proposed Insured to Senior Life Insurance Company to determine eligibility for insurance and/or benefits. Any information used will be subject to the Company's Privacy Policy which is provided with my policy, or upon request. I understand that this Authorization shall remain in force for 24 months following the date of my signature below and may be revoked at any time by sending a written request to the Company. A copy of this Authorization is as valid as the original and a copy will be provided upon request. 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. I affirm that the answers I have given are true to the best of my knowledge and belief. I understand that the Company will rely on my answers in issuing the insurance. I understand that coverage takes effect when this application has been approved by the Company, the first premium is paid, and the policy is issued. 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. 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.

❑ ***Draft First Premium as soon as possible*** ❑ ***Monthly EFT*** ❑ ***Semi-Annual*** ❑ ***Annual***

_____ ***Monthly Draft Date (circle one): 1st , 3rd , 5th , 10th , 15th , 20th , 25th*** ❑***Checking*** ❑***Savings***

Financial Institution Name

Names on Account	***Routing Number (9 digits)***	***Account Number***

OWNER INSURED & PAYOR MUST SIGN HERE

Insured - Payor/Owner if different than Insured	***Signed In State***	***Date***

AGENT MUST SIGN HERE

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 recorderd the answers in full as they were given. To the best of my knowledge, replacement ❑ is ❑ is not involved in this transaction.

Agent (Signature)	***Name (Print)***	***Agent/License Number***