

Application for Senior Life Insurance - CONTINENTAL GENERAL INSURANCE COMPANY -
6201 Johnson Drive – P. O. Box 29136 – Mission, KS 66201-9136



1. Name of Proposed Insured (Print)			Sex	Birthdate			Age	Social Security No.			
Last	First	Initial		Mo.	Day	Year	Nearest Birthday				
Street Address		City		State	Zip		Birth Place State	Telephone No.			
2. Death Benefit		3. Premium		Premium Payable:							
\$ _____		\$ _____		<input type="checkbox"/> Annual			<input type="checkbox"/> Semi-Annual				
				<input type="checkbox"/> Quarterly			<input type="checkbox"/> Monthly Bank Draft (BOM)				
4. Primary Beneficiary			Relationship			Contingent Beneficiary			Relationship		
5. Owner, if other than the Proposed Insured			Name			Relationship			Social Security No.		
Address											
6. Will the proposed insurance replace any existing policy or annuity? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes: Insurance Company Name and Address											
7. Telephone Verification of Your Application To assure that we have all the information needed to process your application you will be contacted by telephone shortly after your agent submits your application. We will ask you a number of questions to be sure that all information on your application is complete and correct. Please indicate the best day/time to call you: _____ Telephone Number: _____											
8. Tobacco Question. Have you used tobacco in any form within the last 2 years? <input type="checkbox"/> Yes <input type="checkbox"/> No											
Medical Questions. If the answer to any of the following questions is Yes, the Proposed Insured will not be eligible for coverage:								Yes	No		
9. Have you ever received medical advice, treatment, been advised to have treatment or surgery, or taken medication for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or have you tested positive for the Human Immunodeficiency Virus?								<input type="checkbox"/>	<input type="checkbox"/>		
10. Have you ever been diagnosed with or treated for a terminal illness?								<input type="checkbox"/>	<input type="checkbox"/>		
11. Have you been hospitalized within the last 30 days or been hospitalized two or more times in the last two years or been confined to a nursing facility in the last two years?								<input type="checkbox"/>	<input type="checkbox"/>		
12. Do you have now, or within the past 2 years, have you received medical advice, treatment, been advised to have treatment or surgery, or taken medication for:											
a) Heart Attack, Heart or Heart Valve Surgery, Angina, Cardiomyopathy, Congestive Heart Failure, Cardiac Pacemaker or Defibrillating Device?								<input type="checkbox"/>	<input type="checkbox"/>		
b) Stroke, Transient Ischemic Attack (TIA), Cerebrovascular Blockage or Insufficiency, Vascular Aneurysm, or high blood pressure not under adequate control?								<input type="checkbox"/>	<input type="checkbox"/>		
c) Internal Cancer, Melanoma, Leukemia, Hodgkin's Disease or Lymphoma?								<input type="checkbox"/>	<input type="checkbox"/>		
d) Chronic Lung Disease, Emphysema, Chronic Obstructive Pulmonary Disease (COPD), or any Chronic Pulmonary Disease requiring the use of oxygen?								<input type="checkbox"/>	<input type="checkbox"/>		
e) Chronic Kidney Disease, Renal Failure, Renal Insufficiency, Chronic Liver Disease, Hepatitis, Cirrhosis, Disease of the Pancreas, or Organ Transplant?								<input type="checkbox"/>	<input type="checkbox"/>		

