KEMPER HEALTH SOLUTIONS

Senior Solutions

Kemper Senior Solutions
P.O. Box 269010
Oklahoma City, Oklahoma 73126
Phone: 877-877-0199
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Fax

To: **Kemper Senior Solutions**

Attention: _____

Date: _____ From: _____

Subject: New Business Fax: _____

Total Pages: _____ Phone: _____

If transmission is poor or incomplete, please notify sender.

Comments:

Insurance Benefits Provided by **Reserve National Insurance Company**

KEMPER HEALTH SOLUTIONS

Application for Life Insurance

Insurance Benefits Provided by Reserve National Insurance Company

Kemper Senior Solutions

APPLICANT

Full Legal Name of Proposed Insured _____

Gender ☐ Male ☐ Female **Social Security No.** ___/___/___ **Date of Birth** ___/___/___

Legal Residence Address _____
Street City State Zip

Mailing Address _____
Street City State Zip

Phone No. ___/___/___ E-mail _____

Name of Owner if other than Proposed Insured _____

MODIFIED WHOLE LIFE POLICY

HOME OFFICE USE: Policy Number(s)

GUARANTEE ISSUE

If you are applying for the Modified Whole Life Policy, please answer the following:

Policy Amount: ☐ $25,000 ☐ $20,000 ☐ $15,000 ☐ $10,000 ☐ $5,000

1. Do you have existing life insurance or annuity contracts in force?	☐ **Yes** ☐ **No**
2. Will this insurance replace in whole or in part any other insurance? *(This policy will not be issued to replace other coverages)*	☐ **Yes** ☐ **No**
3. Do you elect to pay delinquent premiums pursuant to the Automatic Premium Loan Provision?	☐ **Yes** ☐ **No**
4. Do you understand that a reduced death benefit amount may be payable during the first two policy years according to the terms of the policy?	☐ **Yes** ☐ **No**

Agent Statement: To the best of my knowledge the proposed insured ☐ **does** ☐ **does not** have any existing life insurance or annuity contracts.

Payment Mode:

☐ Annual ☐ Monthly (Automated Bank Account Withdrawal)

Initial Premium $_____

Primary Beneficiary	**Relationship to Insured**	**Date of Birth**

If more space is needed, list on a separate sheet.

AGREEMENTS & SIGNATURES

IT IS REPRESENTED THAT ALL STATEMENTS AND ANSWERS CONTAINED IN THIS APPLICATION ARE FULL, COMPLETE AND CORRECTLY RECORDED AND THAT: 1. This application and any supplements thereto will be the basis for and be a part of any insurance issued, and that all statements and answers in this application and any supplements are complete and true to the best of applicant's knowledge and belief. 2. The insurance applied for in this application will not be considered in force until issued by the Company and the first premium paid during the insured's lifetime. The Company shall have 60 days from the date signed in which to consider and act upon this application which the parties agree is a reasonable time. If within such period insurance has not been received by the applicant, or if notice of rejection has not been given, then this application shall be deemed to have been declined by the Company and the Company will return any premium tendered herewith. For purposes of insurability and underwriting determinations by Reserve National Insurance Company, I hereby authorize any physician, medical practitioner, hospital, clinic, pharmacy benefit manager, pharmacy related service organization, or other medical or medically-related facility, insurance company or MIB, Inc. ("MIB"), that has any health or medical records or knowledge concerning me or any members of my family named in this application, to disclose to the Company or its reinsurers any such information upon presentation of this authorization or reproduction thereof. I authorize the Company or its reinsurers to make a brief report of my personal health information to MIB. I, or my authorized representative, am/is entitled to receive a copy of this authorization upon request. This authorization shall remain valid for a period of 24 months from the date hereof. I understand that I may revoke this authorization at any time by mailing written notice thereof to the Company at 601 East Britton Road, Oklahoma City, OK 73114. If this application was taken over the telephone, I state that my answers were correctly recorded and I have signed this application after the telephone call. I understand that the policy applied for provides the following benefit for death occurring while the policy is in force: (a) for non-accidental death during the first two policy years the benefit payable is 120% of the premiums paid as of the date of death; (b) for non-accidental death after the second policy year the face amount is payable; and (c) for accidental death at any time the policy is in force the face amount is payable.

AGREEMENTS & SIGNATURES - CONTINUED

If accepted by the Company, the applicant requests coverage to be effective:

☐ Date of Application ☐ Date of Issue ☐ Other _____

Policy to be Delivered to:

☐ Applicant ☐ Agent

The sum of $ _____ , which is the ☐ **Annual** ☐ **Monthly** initial premium for the policy(ies) applied for, has been ☐ **Paid to** ☐ **Authorized as a draft on my account by** "Kemper Senior Solutions".

Signed at: _____ _____
City State

_____ **Date:** _____
Signature of Proposed Insured

_____ **Date:** _____
Signature of Applicant/Owner/Trustee (if Other than Proposed Insured)

Owner/Trustee Address _____
Street City State Zip

Agent: I certify that I asked each question of the applicant personally and the answers have been accurately recorded hereon.

Signature of Producer #1	**Producer Number**	**Date**
N/A	**N/A**	**N/A**
Signature of Producer #2	**Producer Number**	**Date**
	N/A	
Print Producer #1 Name	**Print Producer #2 Name**	**Agency Name**

BANK DRAFT AUTHORIZATION

Sign the authorization below and provide a voided check from the account you would like to use for our bank draft. Your premium will be paid by your bank and will be reflected in your bank statement.

As a convenience to me, I hereby request and authorize you to pay and charge to my account checks or credits on my account by and payable to Kemper Senior Solutions, Oklahoma City, Oklahoma, provided there are sufficient collected funds in said account to pay the same upon presentation. I agree that your rights in respect to each such check or credit shall be the same as if it were a check drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing, and until you actually receive such notice I agree that you shall be fully protected in honoring any such check or credit. I further agree that if any such check or credit be dishonored, whether with or without cause and whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

_____ _____ ☐ Annual ☐ Monthly
Signature EXACTLY as it appears on Bank Records Date