LIFE INSURANCE — SIMPLIFIED APPLICATION
PART I LUC-128 10/07

Mail completed application to:
Symetra Life Insurance Company
Attn: Keli Roeser
PO Box 84068
Seattle, WA 98124-9918

Symetra Life Insurance Company
777 108th Avenue NE, Suite 1200, Bellevue, WA 98004-5135

PROPOSED INSURED INFORMATION

Insured Name First	Middle	Last	☐ Male ☐ Female	Soc. Sec. No.

Address Street/PO Box	City	State	Zip

Daytime Phone	Evening Phone

Occupation	Annual Income	State or Foreign Country of Birth

Height	Weight	Driver's License #	Date of Birth

Owner if other than Proposed Insured	Soc. Sec./Tax ID:

Owner Address Street/PO Box	City	State	Zip

Insurance Needed For:
☐ Debt Obligations ☐ Family Income Needs ☐ Business Needs ☐ Other _____

BENEFICIARY NAME Relationship		Primary	Contingent	%
		☐	☐	
		☐	☐	
		☐	☐	
Any living children born of this marriage or legally adopted to share equally.		☐	☐	

COVERAGES

Plan Choice

☐ 10-Year Term ☐ 20-Year Term ☐ Other _____

☐ Universal Life Plan (UL) _____ Death Benefit Option (please select one option) ☐ Level ☐ Increasing

Amount of Life Insurance Coverage $_____

Supplemental Benefits ☐ Insured Children's Benefit: No. of units _____ Maximum units 5 (1 unit = $1,000)

☐ Waiver Benefit (UL Only) ☐ Other _____

PERSONAL HISTORY

	Yes	No
1. In the past 12 months, have you used any form of tobacco or nicotine based products?	☐	☐
2. In the past 12 months, has the Proposed Insured been admitted or advised to be admitted to a hospital except for normal childbirth?	☐	☐
3. Is the Proposed Insured currently disabled or unable to perform all the regular duties of his/her occupation?	☐	☐
4. In the past 10 years, has the Proposed Insured had a motor vehicle violation of driving under the influence of alcohol or drugs, had their license suspended, or been convicted of reckless driving, participated in aviation activities as a pilot or crew member, or engaged in parachuting, mountain and/or rock or ice climbing, hang-gliding, or racing of any motor driven vehicle or craft?	☐	☐
5. In the past 10 years, has the Proposed Insured tested positive for or been treated for the Human Immunodeficiency Virus (HIV) infection or been diagnosed by a member of the medical profession as having Acquired Immunodeficiency Syndrome (AIDS) caused by HIV infection or other sickness or condition derived from such infection?	☐	☐

6. In the past 10 years, has the Proposed Insured been hospitalized or received medical advice for:

	Yes	No		Yes	No
Heart disease or disorder	☐	☐	Major depression, bipolar disorder,		
Cancer (not including basal cell)	☐	☐	schizophrenia, or suicide attempt	☐	☐
Leukemia	☐	☐	Stroke or transient ischemic attack	☐	☐
Kidney disease or disorder (not kidney stones)	☐	☐	Lymphom a	☐	☐
Pancreas disease or disorder	☐	☐	Diab etes	☐	☐
Crohn's disease or ulcerative colitis	☐	☐	Liver disease (not hepatitis A)	☐	☐
Central nervous system disease or			Respiratory disease or disorder (not asthma)	☐	☐
disorder (such as MS, epilepsy, paralysis)	☐	☐	Alcohol or drug dependency	☐	☐

REMARKS

Please explain any yes answer to questions 2-6 under Personal History, including doctor names, addresses and dates and treatments. Special Note: If someone other than the Proposed Insured will own this policy, provide name, social security number or Tax I.D. here.

Effective Date:

REPLACEMENT

	Yes	No
7. Do you have any other existing life insurance policies or annuity contracts with this or any other company? (in force or applied for)	☐	☐

Company	Face Amount	Policy Type	Annual Premium

	Yes	No
8. To the best of the applicant's knowledge, will the policy applied for replace any existing life insurance policy or annuity, or is any part of the premium to be paid by policy loan, or cash value on insurance presently in force? (if yes, attach state replacement disclosure)	☐	☐
9. If the policy being replaced has cash value or surrender charges, please provide this information in the remarks section.		

AGENT

	Yes	No
10. Does the applicant have any existing life insurance policies or annuity contracts with this or any other company?	☐	☐
11. To the best of your knowledge, will this insurance replace or change any existing life insurance or annuity?	☐	☐
12. If replacing, how does this policy better serve the applicant's needs?		

PAYMENT AND TEMPORARY INSURANCE

Premium Payment Frequency:

☐ Monthly Automatic Bank Draft (EFT)* ☐ Other Payroll Deduction Payment with Application $_____

For future pa yments taken by EFT, please complete the f ollowing information. *M arking this b ox a uthorizes us to a utomatically deduct from your checking or savings account by electronic funds transfer (EFT).

Name on Account	☐ Checking ☐ Savings	Bank Name
Routing Number	Account Number	Draft Date (date cannot be the 29th, 30th or 31st)

If your face amount is $2 50,000 or les s and you answered "no" to questions 2-6, you will be covered under the temporary insurance agreement if a check is collected for the initial payment or if you sign up for initial payment by EFT.

AUTHORIZATION TO RELEASE PERSONAL INFORMATION

I here by a uthorize and re quest a ny me dical c are provider, p harmacy, pharm acy b enefits m anager, in dividual employer, i nsurance company, reinsuring company, medical examiner, government unit, con sumer reporting agency, or oth er person or organization, and MIB, Inc., to disclos e an y and all medic al information, n on-medical i nformation, emplo yment informati on, a nd i nsurance information t hey h old concerning me , to the emplo yees, ag ents, or attorne ys of S ymetra Life Insuranc e Companies.* This disclos ure a uthorization will permit employees, agents or reinsurers of Symetra Life Insurance Companies to view, copy, be furnished copies, share, or be given details of all such information described above including, but not limited to, mental and physical condition, evaluation, diagnoses, treatment, prognoses, prescription records, and/or toxicology results; specifically to include drug, alcohol use, mental illness, psychiatric treatment or diagnosis, testing and/or treatment of th e Human Immunodeficiency Virus (HIV) and/or other se xually-transmitted dise ases. S ymetra Life Ins urance Companies obtain medical information only in connection with specific products or cl aims. Symetra Life Insurance Companies will not use or shar e personally identifiable medical information for any pur pose other than th e underwriting or a dministration of your p olicy, claim or account. I und erstand th at the inform ation obtained purs uant to this Aut horization will be us ed for th e pur pose of verif ying, e valuating, negotiating, an d other p ertinent leg al us es, with res pect to m y app lication for i nsurance, or cla im under a pol icy of ins urance. T his authorization will expire at the end of the contestability period of any insurance policy issued in reliance on the records obtained through this authorization or twenty-four (24) months after the date of signing this authorization. The individual signing this authorization has the right to revoke an authorization in writing, except to the extent that action has been taken in reliance on the authorization, or during a contestability period. A written statement revoking this authorization delivered to S ymetra Life Ins urance Companies at their usual business addresses will rev oke thi s authoriz ation. An y cop y of this authoriz ation shall h ave the same aut hority as the original. I also understa nd that my representative, or I have a right to receive a copy of this authorization upon request.

I, the Owner, certify under the penalties of perjury that (1) the num ber shown in Applicant Info section is m y correct taxpayer identification number, and (2) I am not subject to backup withholding.

I (we) agree t hat al l the stat ements a nd answers r ecorded o n this application ar e tru e an d com plete to the best of m y/our be lief and knowledge and shall form a part of an y policy issued. I hav e also read the Temporary Life Insurance Agreement. (Maximum Coverage is $250,000)

Any person who, with intent to defraud or knowing he/she is facilit ating a fraud a gainst an insurer, submits an a pplication or files a claim containing a false or deceptive statement may be guilty of insurance fraud.

I acknowledge this insu rance policy was not a p rerequisite to receiv ing credit, prop erty or ser vices from th e bank and tha t th e amount of insurance I am apply ing for ma y no t meet my c omplete fin ancial needs. I ha ve receiv ed information both orally and in writing stating that this insuran ce produc t is not a de posit or other obligation o f, or guaranteed b y, the bank or an affiliate of the bank and that the insurance product is not insured b y the Federal Deposit Insurance Corporation (FDIC) or any other agency of the United States, or an affiliate of the bank.

Signed this _____, at _____, State of _____
Date City State

_____	George E. Daniel, Jr.
Printed Name of Proposed Insured	Print Name of Writing or Authorized Agent
_____	_____
Signature of Proposed Insured (Age 15 or older)	Signature of Writing or Authorized Agent
_____	229-246-3342 / 41-3502
Signature of Applicant/Owner ** if other than Proposed Insured	Agent Phone / Agent Stat Number
	dan@danielhealth.com
	Agent Email

Branch Name _____ Branch # _____ 7-Digit Cost Center # _____ Rep ID # _____

* Symetra Life Insurance Companies include: Symetra Life Insurance Company, Symetra National Life Insurance Company.
** If applicant is corporation/partnership, a corporate officer/partner other than proposed insured must sign.

Submit via Email