Sentinel Security Life Insurance Company

Administrative Office
P.O. Box 16960 · Clearwater, FL 33766-6960

Application For: ☐ **Medicare Supplement Coverage** ☐ **Life Insurance**

Mgr./Commission Code (Required Field For Brokerage)	District Sales Manager/Assoc. Marketer	Application Reviewed By:

MEDICARE SUPPLEMENT PLAN INFORMATION (to be completed by **Producer**)

NOTE: For ALL sections, ONLY complete the Applicant B information if to be insured.

APPLICANT		**APPLICANT B**	
Medicare Supplement Plan	Medicare Select Plan (not available in all states)	Medicare Supplement Plan	Medicare Select Plan (not available in all states)
☐ A ☐ B ☐ C ☐ D ☐ F	☐ C ☐ D ☐ F	☐ A ☐ B ☐ C ☐ D ☐ F	☐ C ☐ D ☐ F
Requested Effective Date		Requested Effective Date	
Mail Policy To: ☐ Insured ☐ Agent		Mail Policy To: ☐ Insured ☐ Agent	
Medicare Supplement Premium Collected $		Medicare Supplement Premium Collected $	
Renewal $		Renewal $	
Renewal Mode A, S, Q, ACH (direct monthly not available)		Renewal Mode A, S, Q, ACH (direct monthly not available)	

1. IF APPLYING FOR MEDICARE SUPPLEMENT AND/OR LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS COMPLETELY.

Applicant	**Applicant B**
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone No (_____)_____ (area code)	Home Phone No (_____)_____ (area code)
Current Age _____ Date of Birth_____ mo/day/ yr	Current Age _____ Date of Birth_____ mo/day/ yr
Male ☐ Female ☐ State of Birth_____	Male ☐ Female ☐ State of Birth_____
Social Security No	Social Security No
Medicare Health Insurance Card Number (if known or applicable)	Medicare Health Insurance Card Number (if known or applicable)
E-mail Address	E-mail Address
Height Weight: Ft _____ In _____ Lbs _____	Height Weight: Ft _____ In _____ Lbs _____
Have you used tobacco in any form in the past 12 months?..... Yes ☐ No ☐	Have you used tobacco in any form in the past 12 months?..... Yes ☐ No ☐

2. IF APPLYING FOR MEDICARE SUPPLEMENT, PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

	Applicant	Applicant B
1. Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the **Outline of Coverage**?	Yes ☐ No ☐	Yes ☐ No ☐
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," what is your Part A effective date? _____ (Applicant) / _____ (Applicant B)		
If "NO," what is your eligibility date? _____ (Applicant) / _____ (Applicant B)		
2. Are you covered under Medicare Part B?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," what is your Part B effective date? _____ (Applicant) / _____ (Applicant B)		
If "NO," indicate date you plan to enroll. _____ (Applicant) / _____ (Applicant B)		
3. Did you turn age 65 in the last six months?	Yes ☐ No ☐	Yes ☐ No ☐
4. Did you enroll in Medicare Part B in the last six months?	Yes ☐ No ☐	Yes ☐ No ☐
If "YES," indicate your effective date. _____ (Applicant) / _____ (Applicant B)		

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.**

3. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

To the Best of Your Knowledge:	Applicant	Applicant B
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.)	Yes ☐ No ☐	Yes ☐ No ☐
2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force?		
(a) If "YES," with what company, and what plan do you have?	Yes ☐ No ☐	Yes ☐ No ☐

Applicant	**Applicant B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date / /	Issue Date / /

(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy?	Yes ☐ No ☐	Yes ☐ No ☐
(c) If "YES," indicate termination date. _____ (Applicant) / _____ (Applicant B)		
(d) **If "YES," have you received a copy of the replacement notice?**	Yes ☐ No ☐	Yes ☐ No ☐
If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.		
3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START_____ (Applicant) END_____ / START_____ (Applicant B) END_____		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	Yes ☐ No ☐	Yes ☐ No ☐
(b) **If "YES," have you received a copy of the replacement notice?**	Yes ☐ No ☐	Yes ☐ No ☐

(c) Reason for termination/disenrollment? _____ (Applicant) / _____ (Applicant B)

(d) Planned date of termination/disenrollment? _____ (Applicant) / _____ (Applicant B)

	Applicant	Applicant B
(e) Was this your first time in this type of Medicare plan?	Yes ☐ No ☐	Yes ☐ No ☐
(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan?	Yes ☐ No ☐	Yes ☐ No ☐
(g) Is your former Medicare supplement or Medicare select policy/certificate still available?	Yes ☐ No ☐	Yes ☐ No ☐
4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.)	Yes ☐ No ☐	Yes ☐ No ☐

(a) If "YES," with what company and what kind of policy/certificate? (List below.)

Applicant		**Applicant B**	
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate

(b) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank.
START_____ END_____ / START_____END_____
Applicant Applicant B

(c) Reason for termination/disenrollment?_____/_____
Applicant Applicant B

(d) Planned date of termination/disenrollment?_____/_____
Applicant Applicant B

	Applicant	Applicant B
5. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.)	Yes ☐ No ☐	Yes ☐ No ☐
If "YES,"		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	Yes ☐ No ☐	Yes ☐ No ☐
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	Yes ☐ No ☐	Yes ☐ No ☐

6. Producers shall list any other health insurance policies/certificates they have sold to the applicant.

(a) List policies/certificates sold which are still in force.

Applicant	**Applicant B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage	Effective Date of Coverage

(b) List policies/certificates sold in the past five (5) years which are no longer in force.

Applicant	**Applicant B**
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage	Effective Date of Coverage

4. IF APPLYING FOR MEDICARE SUPPLEMENT:
- During Open Enrollment or a Guaranteed Issue period, SKIP SECTION 4 and GO TO SECTION 5.
- NOT during Open Enrollment or a Guaranteed Issue period, PLEASE ANSWER ALL QUESTIONS.

IF APPLYING FOR LIFE INSURANCE, PLEASE ANSWER ALL QUESTIONS

If either you or Applicant B answer "YES" to any of the following questions 1-14, that person is not eligible for Medicare Supplement or Life Insurance coverage.

	Applicant	**Applicant B**
1. Are you currently hospitalized, confined to a nursing facility, receiving hospice or home health care; or, are you bedridden or confined to a wheelchair?	Yes ☐ No ☐	Yes ☐ No ☐
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	Yes ☐ No ☐	Yes ☐ No ☐
3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis?	Yes ☐ No ☐	Yes ☐ No ☐
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?	Yes ☐ No ☐	Yes ☐ No ☐
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)?	Yes ☐ No ☐	Yes ☐ No ☐
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? If you do not have diabetes, this question should be answered "NO".	Yes ☐ No ☐	Yes ☐ No ☐
7. Do you have diabetes that has ever required more than 50 units of insulin daily?	Yes ☐ No ☐	Yes ☐ No ☐
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?	Yes ☐ No ☐	Yes ☐ No ☐
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?	Yes ☐ No ☐	Yes ☐ No ☐
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	Yes ☐ No ☐	Yes ☐ No ☐
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	Yes ☐ No ☐	Yes ☐ No ☐
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes ☐ No ☐	Yes ☐ No ☐
13. Have you been hospital confined three or more times in the last two years?	Yes ☐ No ☐	Yes ☐ No ☐
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes ☐ No ☐	Yes ☐ No ☐
15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please list the drug and the condition in the following table.	Yes ☐ No ☐	Yes ☐ No ☐

Applicant (please attach a separate sheet if needed)		**Applicant B** (please attach a separate sheet if needed)
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

5. IF APPLYING FOR LIFE INSURANCE, PLEASE COMPLETE ALL QUESTIONS

NOTE: If you are in Open Enrollment or eligible for Guaranteed Issue for a Medicare Supplement policy and are applying for Life Insurance, you must answer all the questions in Section 4 of the application.

APPLICANT	APPLICANT B (If applying for coverage)
Beneficiary Name	Beneficiary Name
Relationship to Applicant	Relationship to Applicant B
Face Amount: ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ Other_____ Automatic Premium Loan provision (if available) Yes ☐ No ☐	Face Amount: ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ Other_____ Automatic Premium Loan provision (if available) Yes ☐ No ☐
Life Insurance Premium Collected: $	Life Insurance Premium Collected: $
Mode: A, S, Q, ACH	Mode: A, S, Q, ACH

	Applicant	**Applicant B**
1. Are you a citizen of the United States? If "No," complete Foreign National and Foreign Travel Questionnaire	Yes ☐ No ☐	Yes ☐ No ☐

2. List below all life insurance policies and/or annuity contracts on the Applicants that have terminated in the last 13 months, are now in force (including any that have been assigned or sold), or that are now pending. (This includes any life insurance policies and/or annuity contracts under a binding or conditional receipt or within an unconditional refund period.) **If none, check the following box:** ☐ None
3. List below if you have had or intend to have, any life insurance policies and/or annuity contracts replaced, converted, reduced, reissued, sold, subjected to borrowing, or otherwise discontinued because of this application.
The Producer shall comply with any additional state and/or company replacement requirements.

Company	Applicant	Policy or Contract Number	Face Amount	Pending?	ADB Amount	1035 Exchange?	To Be Replaced or Converted?	Assigned or Sold?
				Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐
				Yes ☐ No ☐		Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

6. BILLING INFORMATION

I would like my monthly direct payment to come from my (check one) on the _____ day of the month:

☐ Checking **Please attach a voided check** ☐ Savings **Please ask your financial institution to verify that this EFT will be accepted and that the information below is correct.**

Financial Institution Name:	Phone #:
Financial Institution Address:	
Transit Routing #:	Account #:

I hereby request and authorize Sentinel Security Life to initiate a charge to my account at the named Financial Institution to pay the premium(s) due, after the first premium has been paid, on any policy issued in connection with this application. The term "charge" shall include items initiated by electronic means, checks, drafts or any other order. I have the right to stop payment of a charge by giving notice to Sentinel Security Life or the Financial Institution in such time as to afford a reasonable opportunity to act prior to charging my account. I agree that Sentinel Security Life's rights in respect to each charge shall be the same as if it were a check made payable to Sentinel Security Life and personally signed by me. If any charge is dishonored for any reason, Sentinel Security Life shall not be under any liability even though such dishonor results in the forfeiture of insurance.

_____ _____

Signature as it appears on financial institution records | Print name of account owner (if other than proposed insured)

_____

Date

7. PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I understand the Company may obtain an investigative consumer report on me and a telephone interview may be necessary to verify or supplement information given to the Company on this application. I understand my right to request to be interviewed and that I may request a copy of the report if no personal interview is conducted. A photocopy of this form will be as valid as the original; this Authorization and Acknowledgment will be valid for 24 months after it is signed.

Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to civil fines and criminal penalties.

☐ I wish to apply for a Medicare supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, (a) upon acceptance of the completed application, each applicant will receive a separate policy; (b) my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Sentinel Security Life Insurance Company.

☐ I wish to apply for a Life insurance policy. I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. The life insurance policy applied for will not take effect until it is issued by us and all of the following requirements are met: (a) the policy is delivered to and accepted by the policy owner; (b) the first full premium has been paid according to the mode of payment specified in the application; (c) the Proposed Insured is still alive; and (d) there has been no change in the Proposed Insured's health or habits, or the answers to any of the questions in the application, from the date the application is approved by Sentinel Security's underwriting Department to the date the policy is delivered and accepted by the policy owner.

Dated at _____, on _____, _____ _____

City State Month Day Year Applicant's Signature

Dated at _____, on _____, _____ _____

City State Month Day Year Applicant B's Signature (if applying)

Premium Must Accompany Application

I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

_____ _____

(Signature of Licensed Producer) (Signature of Licensed Producer)

V000007297

_____ _____

PRODUCER NUMBER / (STAMP) PRODUCER NUMBER / (STAMP)

ADDITIONAL INFORMATION: PART 4 - CON'T. HEALTH /MEDICAL QUESTIONS - Question #15		
Applicant (please attach a separate sheet if needed)		**Applicant B** (please attach a separate sheet if needed)
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

SECTION FOR ADDITIONAL COMMENTS	
Applicant (please attach a separate sheet if needed)	**Applicant B** (please attach a separate sheet if needed)

SENTINEL SECURITY LIFE INSURANCE COMPANY
Administrative Office P.O. Box 16960, Clearwater, FL 33766-6960 (888) 510-0668

Agent Certification

I the undersigned insurance agent certify;

THAT, I have taken an application for:

Primary Insured:		**Spouse:**	
Medicare Supplement	Medicare Select	Medicare Supplement	Medicare Select
☐ Plan A	☐ Plan C	☐ Plan A	☐ Plan C
☐ Plan B	☐ Plan D	☐ Plan B	☐ Plan D
☐ Plan C	☐ Plan F	☐ Plan C	☐ Plan F
☐ Plan D		☐ Plan D	
☐ Plan F		☐ Plan F	

Offered by **SENTINEL SECURITY LIFE INSURANCE COMPANY,**

to _____
(Applicant(s)),

THAT, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of

$_____ which has been paid to me by

☐ Check ☐ Money Order ☐ ACH (Check appropriate method of payment)

THAT, I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services in connection with this insurance policy being applied for.

_____ _____
Date Signature of Agent

I, the undersigned applicant, understand that I will receive a copy of this form when my policy is issued and delivered to me.

_____
Name of Agency

_____ _____
Signature of Applicant Address of Agent / Agency

_____ _____
Signature of Spouse, if applying Phone Number

SENTINEL SECURITY LIFE INSURANCE COMPANY
Administrative Office P.O. Box 16960, Clearwater, FL 33766-6960 (888) 510-0668

Medical Release

Authorization to Release Confidential Medical Information

Records and information obtained will be disclosed to Sentinel Security Life Insurance Company for the purpose of 1) evaluating my application for insurance; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) and administer coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, the Medical Information Bureau, Inc. (MIB), or anyone else to release any and all records and information to be exchanged between Sentinel Security Life Insurance Company and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and it assigns as necessary to fulfill the purpose of this disclosure.

I hereby authorize you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG's.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Sentinel Security Life Insurance Company at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Sentinel Security Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

Name of Proposed Insured (please print)	Name of Proposed Insured B (please print)
Signature of Proposed Insured	Signature of Proposed Insured B
DATE	DATE

Calculate Your Premium

Medicare Supplement

Medicare Supplement Plan _____

Before you begin: *If you're not in your open enrollment or guarantee issue period, please go to page 2 to determine your eligibility for coverage.*

Steps	**Example** Rate displayed is used for calculation purposes only.	Applicant's Premium	Applicant B's Premium
Premium Write in your Medicare supplement plan's premium from the Outline of Coverage table.	$128.52		
Payment Options To determine other payment schedules, multiply your monthly premium by: 3 to pay four times a year (quarterly) 6 to pay twice a year (semi-annually) 12 to pay once a year (annually)	$128.52 Monthly Payment $385.56 Quarterly Payment $771.12 Semi-Annual Payment $1,542.24 Annual Payment		
Enrollment/Policy Fee There is a one-time application fee of $25. **This will be collected with your initial payment and will NOT affect your renewal premium.**	$128.52 + $25.00 = $153.52 Example shows initial payment (monthly schedule).		

Calculate Your Premium

New Vantage I Life

TO ADD NEW VANTAGE I LIFE INSURANCE

For total face amounts other than $5,000, $7,500, or $10,000, multiply the "Per $1,000" column by the number of units applied for and add the $3.01 monthly policy fee in at the end of your calculation.			Applicant's Premium Calculation	Spouse's Premium Calculation
Choose the base face amount of life insurance coverage you want to purchase ($5,000, $7,500 or $10,000)	Base Face Amount $ 5,000 (Example based on Male age 75 non-smoker)	Premium Amount $49.30		
Add any additional $1,000 Face Amount increments	1 Additional $1,000 increments x $9.26 per $1,000	Total additional increment premium = $9.26		
Payment Options Multiply monthly premium by: 3.08 for a quarterly premium 6.05 for a semi-annual premium 11.63 for an annual premium **BILLING MODE MUST BE THE SAME AS THE MEDICARE SUPPLEMENT**	$49.30 base premium $9.26 additional increments = $58.56 total monthly premium for life insurance x3.08 (Quarterly) = $180.36 x6.05 (Semi-Annual)=$354.29 x11.63 (Annual) = $681.05	Total Life Premium $49.30 + $9.26 = $58.56		
Add the Medicare Supplement (from top section) and Life Insurance premiums (this section) together	$153.52 (Med Supp) + $ 58.56 (Life Ins) = $212.08	One check payable to Sentinel Security Life for $212.08		

COMPLETE AND RETURN WITH APPLICATION

Height and Weight Charts

To determine whether you may purchase coverage, locate your height, then weight in the charts below. If your weight is not in the Standard column for either product, we're sorry, you're not eligible for coverage at this time. If your weight is located in the Standard column for one or both products, you may proceed in completing the application.

MEDICARE SUPPLEMENT

	Decline	Standard	Decline
Hieght	Weight	Weight	Weight
4' 2''	< 54	54 – 145	146 +
4' 3''	< 56	56 – 151	152 +
4' 4''	< 58	58 – 157	158 +
4' 5''	< 60	60 – 163	164 +
4' 6''	< 63	63 – 170	171 +
4' 7''	< 65	65 – 176	177 +
4' 8''	< 67	67 – 182	183 +
4' 9''	< 70	70 – 189	190 +
4' 10''	< 72	72 – 196	197 +
4' 11''	< 75	75 – 202	203 +
5' 0''	< 77	77 – 209	210 +
5' 1''	< 80	80 – 216	217 +
5' 2''	< 83	83 – 224	225 +
5' 3''	< 85	85 – 231	232 +
5' 4''	< 88	88 – 238	239 +
5' 5''	< 91	91 – 246	247 +
5' 6''	< 93	93 – 254	255 +
5' 7"	< 96	96 – 261	262 +
5' 8''	< 99	99 – 269	270 +
5' 9''	< 102	102 – 277	278 +
5' 10''	< 105	105 – 285	286 +
5' 11''	< 108	108 – 293	294 +
6' 0''	< 111	111 – 302	303 +
6' 1''	< 114	114 – 310	311 +
6' 2''	< 117	117 – 319	320 +
6' 3''	< 121	121 – 328	329 +
6' 4''	< 124	124 – 336	337 +
6' 5''	< 127	127 – 345	346 +
6' 6''	< 130	130 – 354	355 +
6' 7''	< 134	134 – 363	364 +
6' 8''	< 137	137 – 373	374 +
6' 9''	< 140	140 – 382	383 +
6' 10''	< 144	144 – 392	393 +
6' 11''	< 147	147 – 401	402 +
7' 0''	< 151	151 – 411	412 +
7' 1''	< 155	155 – 421	422 +
7' 2''	< 158	158 – 431	432 +
7' 3''	< 162	162 – 441	442 +
7' 4''	< 166	166 – 451	452 +

NEW VANTAGE I LIFE

Height	Average Weight	New Vantage I Standard Weight
4'8"	107	75 – 160
4'9"	111	78 – 166
4'10"	115	81 – 172
4'11"	119	83 – 178
5'0"	123	86 – 184
5'1"	129	90 – 193
5'2"	135	95 – 202
5'3"	141	99 – 211
5'4"	147	103 – 220
5'5"	153	107 – 229
5'6"	159	111 – 238
5'7"	165	116 – 247
5'8"	171	120 – 256
5'9"	177	124 – 265
5'10"	183	128 – 274
5'11"	189	132 – 283
6'0"	195	137 – 292
6'1"	200	140 – 299
6'2"	205	144 – 307
6'3"	210	147 – 314
6'4"	215	151 – 322
6'5"	220	154 – 329
6'6"	225	158 – 337

SENTINEL SECURITY LIFE INSURANCE COMPANY
Administrative Office P.O. Box 16960, Clearwater, FL 33766-6960 (888) 510-0668

Notice to Applicant regarding replacement of Medicare supplement insurance or Medicare Advantage
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement insurance or Medicare Advantage and replace it with a policy to be issued by Sentinel Security Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT
I HAVE REVIEWED YOUR CURRENT MEDICAL FOR HEALTH INSURANCE COVERAGE. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

_____

- ☐ Other. (Please Specify) _____

1. State laws provide that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

2. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for any company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____ _____
Signature of Agent / Broker / Other Representative | Print Name and Address of Issuer / Agent / Broker

_____ _____
Signature of Applicant | Signature of Spouse, if applying

_____
Date

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_____
Date

SENTINEL SECURITY LIFE INSURANCE COMPANY
Administrative Office P.O. Box 16960, Clearwater, FL 33766-6960 (888) 510-0668

INVESTIGATIVE CONSUMER REPORT NOTICE TO APPLICANT

Federal law requires that notice of investigation be given to persons applying for insurance. In making this application for insurance to Sentinel Security Life Insurance Company (the Company), it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living (the term "mode of living" does not relate directly or indirectly to the sexual orientation of any proposed insured). You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon proper identification, you have the right to inspect and/or receive a copy of the report from the consumer reporting agency. You have the right to make a written request to the Company within a reasonable period of time to receive additional detailed information about the nature and scope of the investigation. Write to: Underwriting Department, Sentinel Security Life Insurance Company, P.O. Box 16960, Clearwater, Florida, 33766-6960.

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Sentinel Security Life Insurance Company (the Company) or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

MEDICARE SUPPLEMENT/SELECT INITIAL PREMIUM RECEIPT

MAKE CHECK PAYABLE TO: SENTINEL SECURITY LIFE INSURANCE COMPANY

Received from _____ (Proposed Insured) an application for a Medicare Supplement Policy with Sentinel Security Life Insurance Company (the Company), Salt Lake City, Utah and $ _____ for the initial premium. In the event the application is not accepted by the Company, the above amount will be refunded. No obligation is incurred by the Company unless said application is approved by the Company at its Administrative Office and a policy is issued.

_____	_____	_____
Agent's Name (please print)	Agent's Signature	Date

LIFE INSURANCE CONDITIONAL COVERAGE RECEIPT

(Void if altered or modified, or if check or draft given in payment is not honored. **Note: Detach if full first life premium is not paid.)**

Received from _____ $_____ subject to the terms and conditions below, for the full first premium with the application bearing the date of this receipt.

Coverage under any policy issued from an application bearing the date of this receipt will take effect on the later of the following dates: (1) the date of the application; or (2) the date of the last of any medical exams or tests, if required. Coverage will take effect only if each and every one of these conditions have been met: (1) all persons proposed for insurance are in good health; (2) the first full premium is paid on the date of the application; and (3) upon receipt of the application and of any further information required, all persons are insurable as of that date: (a) as determined by Sentinel Security Life Insurance Company (Company) at its home office according to its rules and practices; and (b) at the standard rates for insurance exactly as applied for. The maximum amount of life insurance (excluding accidental death benefits) on the proposed insured (combined with any issued or pending with the Company) which will take effect under this receipt shall not exceed $50,000.

Coverage under any policy not issued exactly as applied for or in excess of the maximum amounts stated above will only take effect: (1) when this policy is delivered to and accepted by the applicant; and (2) upon payment of the first premium for such coverage. This must occur during the lifetime and good health of all persons proposed for insurance (including accidental death benefits).

If a proposed insured dies by suicide while sane or self destruction while insane, we will pay only a refund of all premiums paid. Except as stated above, no insurance will take effect and the liability of the Company is limited to a refund of any amount paid. Any application not accepted or declined will be deemed declined on the 60th day after its date.

_____	_____	_____
Agent's Name (please print)	Agent's Signature	Date

Please mail your completed form to:

Medicare Options

Attention: Rick Plata
23331 Via Sausalito
Moreno Valley, CA 92557

Or

Fax to: (888) 391- 0562

Enrollment questions, please call Rick Plata at (888) 235-8060.