

Please print out the form below and  
mail your completed form to:

Sentinel Medicare  
Enrollment Services

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



**2. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.**

1. Have you received a copy of the <b>Guide to Health Insurance for People with Medicare</b> and the <b>Outline of Coverage</b> ?	<b>Applicant</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Applicant B</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you used tobacco in any form in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>To the Best of Your Knowledge:</b>		
1. Are you covered under Medicare Part A? If "YES," what is your Part A effective date? _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "NO," what is your eligibility date? _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Are you covered under Medicare Part B? If "YES," what is your Part B effective date? _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "NO," indicate date you plan to enroll. _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Did you turn age 65 in the last six months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Did you enroll in Medicare Part B in the last six months? If "YES," indicate your effective date. _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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:	<b>Applicant</b> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Applicant B</b> Yes <input type="checkbox"/> No <input type="checkbox"/>
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.)	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

<b>Applicant</b>	<b>Applicant B</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? (c) If "YES," indicate termination date. _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(d) If "YES," have you received a copy of the replacement notice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>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.</b>		
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 _____ END _____ / START _____ END _____ Applicant Applicant B		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy? (b) If "YES," have you received a copy of the replacement notice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) Reason for termination/disenrollment? _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(d) Planned date of termination/disenrollment? _____ / _____ Applicant Applicant B		

(e) Was this your first time in this type of Medicare plan? (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? (g) Is your former Medicare supplement or Medicare select policy/certificate still available? 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.) (a) If "YES," with what company and what kind of policy/certificate? (List below.)		<b>Applicant</b> Yes <input type="checkbox"/> No <input type="checkbox"/>  Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	<b>Applicant B</b> Yes <input type="checkbox"/> No <input type="checkbox"/>  Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Applicant</b>		<b>Applicant B</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 _____ <div style="display: flex; justify-content: space-around; width: 100%;"> <span>Applicant</span> <span>Applicant B</span> </div>			
(c) Reason for termination/disenrollment? _____ / _____ <div style="display: flex; justify-content: space-around; width: 100%;"> <span>Applicant</span> <span>Applicant B</span> </div>			
(d) Planned date of termination/disenrollment? _____ / _____ <div style="display: flex; justify-content: space-around; width: 100%;"> <span>Applicant</span> <span>Applicant B</span> </div>			
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.) If "YES," (a) Will Medicaid pay your premiums for this Medicare supplement policy? (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?		Yes <input type="checkbox"/> No <input type="checkbox"/>  Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>  Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
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.			
<b>Applicant</b>		<b>Applicant B</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.			
<b>Applicant</b>		<b>Applicant B</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	

**If you are applying during Open Enrollment or a Guaranteed Issue period, SKIP SECTION 4 and GO TO SECTION 5.**

**4. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.** Make sure all questions are answered by each applicant. If either you or Applicant B answer “YES” to any of the following questions 1-14, that person is not eligible for coverage.

	<b>Applicant</b>	<b>Applicant B</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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Have you been diagnosed with Alzheimer’s Disease, Senile Dementia, or any other cognitive disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Do you have diabetes that has ever required more than 50 units of insulin daily?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Have you been hospital confined three or more times in the last two years?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
<b>Applicant</b> (please attach a separate sheet if needed)		<b>Applicant B</b> (please attach a separate sheet if needed)
	Medication Name (copy off pharmacy label)	
	Date <b>Originally</b> Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date <b>Originally</b> Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

5. BILLING INFORMATION	
<b>I would like my monthly direct payment to come from my (check one) on the _____ day of the month:</b> <input type="checkbox"/> Checking <b>Please attach a voided check</b> <input type="checkbox"/> Savings <b>Please ask your financial institution to verify that this EFT will be accepted and that the information below is correct.</b>	
Financial Institution Name:	Phone #:
Financial Institution Address:	
Transit Routing #:	Account #:
<p>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.</p>	
_____	_____
Signature as it appears on financial institution records	Print name of account owner (if other than proposed insured)
_____	
Date	

**6. 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 reinstated 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 reinstated 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 reinstated 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 reinstated 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 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 understand that the first premium includes a one-time enrollment fee of \$25.00.

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 may be guilty of a crime and may be subject to civil fines and criminal penalties. 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.

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)

\_\_\_\_\_  
 PRODUCER NUMBER / (STAMP)

\_\_\_\_\_  
 PRODUCER NUMBER / (STAMP)



**Sentinel Security Life Insurance Company**  
**Administrative Office**  
**P.O. Box 16960**  
**Clearwater, FL 33766-6960**

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 or other Representative

\_\_\_\_\_  
PRINTED Name and Address of Issuer, Agent, or Broker

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Signature of Spouse, if applying

\_\_\_\_\_  
Date

**Sentinel Security Life Insurance Company**  
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\_\_\_\_\_ Other. (Please Specify) \_\_\_\_\_

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\_\_\_\_\_  
Signature of Agent, Broker or other Representative

\_\_\_\_\_  
PRINTED Name and Address of Issuer, Agent, or Broker

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Signature of Spouse, if applying

\_\_\_\_\_  
Date