

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

# Sentinel Security Life Insurance Company

Administrative Office

P.O. Box 16960

Clearwater, FL 33766-6960

## Application For Medicare Supplement Coverage

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

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

<u>APPLICANT</u>		<u>APPLICANT B</u>	
Medicare Supplement Plan		Medicare Supplement Plan	
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F	
Requested Effective Date		Requested Effective Date	
Mail Policy To: <input type="checkbox"/> Insured <input type="checkbox"/> Producer		Mail Policy To: <input type="checkbox"/> Insured <input type="checkbox"/> Producer	
Premium Collected \$		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. PLEASE READ THE FOLLOWING CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY.**

<b>Applicant</b>	<b>Applicant B</b>
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address
City	City
State <span style="float: right;">ZIP</span>	State <span style="float: right;">ZIP</span>
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State <span style="float: right;">ZIP</span>	State <span style="float: right;">ZIP</span>
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 <input type="checkbox"/> Female <input type="checkbox"/> State of Birth _____	Male <input type="checkbox"/> Female <input type="checkbox"/> State of Birth _____
Social Security No	Social Security No
Medicare Health Insurance Card Number (if known)	Medicare Health Insurance Card Number (if known)
E-mail Address	E-mail Address
Height Weight Ft _____ In _____ Lbs _____	Height Weight Ft _____ In _____ Lbs _____



(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.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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)

