Sentinel Security Life

Lighting the way to financial security

Sentinel Security Life Insurance Company

Medicare Supplement Insurance

Standard / Select Medicare Supplement / Life Insurance Plan TEXAS

SENTINEL SECURITY LIFE INSURANCE COMPANY
PO BOX 27248 SALT LAKE CITY, UTAH 84127-0248
STATE OF DOMICILE: UTAH

Agent Checklist for Completing the Medicare Supplement Standard / Select / Life Application

This packet contains the following forms needed to complete a Medicare Supplement Standard / Select and Life Insurance application. Please tear out the **application** and all pages marked **"RETURN TO COMPANY"** and leave the remaining pages with the applicant(s). Please review the following information carefully and complete all needed forms:

☐ **Application for Medicare Supplement Standard / Select and Life Insurance** *(Form SSLCOMB10-TX Rev 070119)*
- Medicare Supplement Standard / Select - If the applicant(s) is applying during Open Enrollment or a Guaranteed Issue period, Section 6 is not required to be completed.
- Life Insurance – Section(s) 6 & 7 are required in all cases if the applicant(s) would like to apply for life insurance.
  - A personal history interview is required for all applicants applying for life insurance. To complete a point of sale interview, call Apptical at (800) 737-6972.
  - The effective date for the life insurance policy will be the same as the Medicare Supplement policy unless otherwise indicated in Section 7 of the application.
- Section 5 should only be completed if the applicant(s) would like his/her payments to be deducted automatically from their checking/savings account. This option only applies if premiums are paid monthly.

☐ **Authorization to Release Confidential Medical Information** *(Form SSLHIPAA3-OT)* - Must be completed **only** if applying outside Open Enrollment or a Guaranteed Issue period for Medicare Supplement Standard / Select **or** if applying for life insurance. If a husband and wife are both applying for coverage on the same application then both must sign the form.

☐ **Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage** *(Form SSLMED-REP-TX)* - This form must be completed if any replacement of an existing Medicare Supplement/Select policy is involved. One signed copy must be returned to the Home Office and the other signed copy must be left with the applicant(s).

☐ **Agent Certification** *(Form SSLMED-CERT-OT Rev 08/14)* - This form must be signed by the agent and by the applicant(s).

☐ **Calculate Your Premium** – This form is used to calculate the correct life insurance premium and, in coordination with the Outline of Coverage, to calculate the correct Medicare Supplement Standard / Select premium. This form must be returned with the application.

☐ **Notice for Replacement of Life Insurance or Annuities** *(Form REP Rev 03/08)* - This form must be completed if any replacement of existing life insurance is involved. One signed copy must be returned to the Home Office and the other signed copy must be left with the applicant(s).

☐ **Investigative Consumer Report Notice to Applicant, Medical Information Bureau Disclosure Notice, Med Supplement/Select Initial Premium Receipt, and Life Insurance conditional receipt** *(Form SSLMED101-OT)* – The Initial/Conditional Premium Receipts must be left with the applicant(s) and the full modal premium is required with all applications.

☐ **Medicare Select Disclosure Statement** *(Form SSLMED-SEL10-DISC-TX)* - Must be left with the applicant(s) for Medicare Select applications.

☐ **Acknowledgement of Receipt of Medicare Select Disclosure Statement** *(Form SSLMED-SEL-ACK-OT)* -Signed acknowledgement must be submitted with Medicare Select applications.

☐ **Fax Transmittal** – Follow the instructions on this form only if the applicant(s) elects to pay premiums using ACH and you would like to fax the underwriting documents instead of mailing them.

Please note, you are also required to provide the applicant(s) with the following items:

☐ **Medicare Select Hospital Network Listing**

☐ **Guide to Health Insurance for People with Medicare**

☐ **Outline of Coverage**

Premiums and Policy Fee

Utilize the Sentinel Security Whole Life New Vantage I premium chart to determine the correct monthly life insurance premium. Utilize the Outline of Coverage to determine Medicare Supplement/Select premiums:

- Determine ZIP code where the client resides and find the correct rate page for that ZIP code.
- Determine Plan.
- Determine if non-tobacco or tobacco.
- Find Age/Gender - Verify that the age and date of birth are the exact age as of the application date, this will be your base monthly premium.
- Use the Calculate Your Premium form to adjust the monthly premium for different modes and to add the policy fee.

There will be a one-time Medicare Select application fee of $25.00 that must be collected with each applicant's initial payment. For a husband and wife written on the same application, $50.00 in fees must be collected. This will not affect the renewal premiums.

Mailing Address
Sentinel Security Life Insurance Company
PO Box 27248
Salt Lake City, UT 84127-0248

Federal Express/UPS
Sentinel Security Life Insurance Company
1405 West 2200 South
Salt Lake City, UT 84119

Fax/Email
Attn: New Business - **ACH Applications 888-433-4795**
newbusiness@sslco.com

SENTINEL SECURITY LIFE INSURANCE COMPANY

P.O. Box 27248 Salt Lake City, Utah 84127-0248
Phone: 1-800-247-1423

Application For: ☐ **Medicare Supplement Coverage** ☐ **Life Insurance**
☐ **Medicare Supplement Conversion; Policy Number** _____

Agent Name(s) / Agent Number (s):

SECTION 1: PLAN (to be completed by Agent)

NOTE: For ALL sections, ONLY complete the Applicant B information if second applicant also applying

APPLICANT		APPLICANT B	
Medicare Supplement Plan	**Medicare Select Plan**	**Medicare Supplement Plan**	**Medicare Select Plan**
☐A ☐B ☐C* ☐D ☐F* ☐G ☐N	☐C* ☐D ☐F* ☐N	☐A ☐B ☐C* ☐D ☐F* ☐G ☐N	☐C* ☐D ☐F* ☐N
*Plan C or F is only available for those first eligible prior to January 1, 2020		*Plan C or F is only available for those first eligible prior to January 1, 2020	
Requested Effective Date:		Requested Effective Date:	
Mail Policy To: ☐ Insured ☐ Agent		Mail Policy To: ☐ Insured ☐ Agent	

SECTION 2: APPLICANT INFORMATION - 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.	Home Phone No.
E-mail Address	E-mail Address
Date of Birth: Current Age _____	Date of Birth: Current Age _____
☐ Male ☐ Female State of Birth:	☐ Male ☐ Female State of Birth:
Social Security No.	Social Security No.
Medicare Health Insurance Card Number or Medicare Beneficiary Identifier	Medicare Health Insurance Card Number or Medicare Beneficiary Identifier
Height / Weight: Ft. _____ In. _____ Lbs. _____	Height / Weight: Ft. _____ In. _____ Lbs. _____
Have you used tobacco in any form, an electronic cigarette (e-cig) or other nicotine delivery product in the past 12 months? ☐ Yes ☐ No	Have you used tobacco in any form, an electronic cigarette (e-cig) or other nicotine delivery product in the past 12 months? ☐ Yes ☐ No
Are you applying for coverage because you have been diagnosed or treated for End State Renal Disease (ESRD) or Kidney Disease requiring dialysis? ☐ Yes ☐ No	Are you applying for coverage because you have been diagnosed or treated for End State Renal Disease (ESRD) or Kidney Disease requiring dialysis? ☐ Yes ☐ No

SECTION 3: PLEASE ANSWER ALL QUESTIONS COMPLETELY

	Applicant	Applicant B
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 or have you enrolled in Medicare Part B in the last six months?	☐ 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. Have you turned 65 in the last six months or will you turn 65 within the next six months?	☐ Yes ☐ No	☐ Yes ☐ No

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.**

SECTION 4: FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

	Applicant	Applicant B
To the Best of Your Knowledge:		
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 inforce?	☐ Yes ☐ No	☐ Yes ☐ No
(a) If "YES," with what company and what plan do you have?		

APPLICANT	APPLICANT B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date	Issue Date

	Applicant	Applicant B
(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-e) 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) Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
(d) Did you drop a Medicare Supplement or Medicare Select policy/certificate to enroll in this Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
(e) Is your former Medicare Supplement or Medicare Select policy/certificate still available?	☐ Yes ☐ No	☐ Yes ☐ No

4. Have you had coverage under any 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.)	☐ Yes ☐ No	☐ Yes ☐ No

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

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

SECTION 5: BILLING INFORMATION

Initial Premium (including app fee)	Initial Premium (including app fee)
$ _____ + $ _____ = $ _____	$ _____ + $ _____ = $ _____
Amount Collected: _____	Amount Collected: _____
Renewal Premium $ _____	Renewal Premium $ _____
Select Premium Payment Option: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ ACH Monthly (direct monthly not available)	Select Premium Payment Option: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ ACH Monthly (direct monthly not available)

I would like my monthly premium 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 # (9 digits):	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

SECTION 6: IF APPLYING FOR MEDICARE SUPPLEMENT:

- **During Open Enrollment or a Guaranteed Issue period, SKIP SECTION 6 and GO TO SECTION 7.**
- **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 or 15A-E, that person is not eligible for Medicare Supplement or Life Insurance coverage.

	Applicant	**Applicant B**
1. Are you currently hospitalized, in a nursing home or assisted living facility, receiving hospice or home health care; or, are you bedridden, wheelchair bound, using oxygen or require the use of a motorized device?	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorder?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you been diagnosed with Parkinson's Disease, systemic lupus, scleroderma, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with related fractures, cirrhosis or chronic hepatitis?	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you been diagnosed with or taken medication for Alzheimer's Disease, 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. Within the past 24 months have you been treated for or been advised by a physician to have treatment for internal cancer, alcohol or drug use, mental or nervous disorder requiring psychiatric care or have you had an amputation caused by disease?	☐ Yes ☐ No	☐ Yes ☐ No
7. Within the past 24 months 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 cardiomyopathy, stroke, Transcient Ischemic Attack (TIA) or heart rhythm disorder?	☐ Yes ☐ No	☐ Yes ☐ No
8. Within the past 24 months 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
9. Has a physician advised you to have cataract surgery in the next 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
10. Has a physician advised you to have surgery, medical tests, treatment or therapy that has not been performed?	☐ Yes ☐ No	☐ Yes ☐ No
11. Have you been hospital confined three or more times in the last 24 months?	☐ Yes ☐ No	☐ Yes ☐ No
12. Have you had an organ transplant or been advised by a physician to have an organ transplant?	☐ Yes ☐ No	☐ Yes ☐ No
13. At any time, have you been medically diagnosed with, treated for, or had surgery for Chronic Kidney Disease, kidney failure, or had Kidney Disease requiring dialysis?	☐ Yes ☐ No	☐ Yes ☐ No
14. Do you have diabetes that has ever required more than 50 units of insulin daily?	☐ Yes ☐ No	☐ Yes ☐ No
15. Do you have diabetes that is treated by medication or diet?	☐ Yes ☐ No	☐ Yes ☐ No
A. Neuropathy or numbness in your hands, feet or legs?	☐ Yes ☐ No	☐ Yes ☐ No
B. Retinopathy or eye disorder (other than cataracts)?	☐ Yes ☐ No	☐ Yes ☐ No
C. Kidney Disease?	☐ Yes ☐ No	☐ Yes ☐ No
D. Skin ulcers or had an amputation?	☐ Yes ☐ No	☐ Yes ☐ No
E. Heart disorder (including high blood pressure), poor circulation or Peripheral Vascular Disease, history of stroke or TIA?	☐ Yes ☐ No	☐ Yes ☐ No
16. Are you taking or have you taken any prescription or over-the-counter medications within the past 24 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 of pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy of pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

ADDITIONAL INFORMATION: PART 6- CON'T HEALTH/MEDICAL QUESTIONS		
	Medication Name (copy of pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy of pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy of pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

IF ADDITIONAL SPACE IS REQUIRED ATTACH SEPARATE SHEET

SECTION 7: IF APPLYING FOR WHOLE LIFE INSURANCE, PLEASE COMPLETE ALL QUESTIONS

NOTE: If you are in Open Enrollment or eligible for Guaranteed Issue for Medicare Supplement policy, and are applying for Whole Life Insurance, you must answer all of the questions in Section 6 of the application.

APPLICANT	**APPLICANT B** (if applying for coverage)
Beneficiary Name	Beneficiary Name
Relationship to Applicant	Relationship to Applicant
Face Amount: ☐ $5,000 ☐ $7,000 ☐ $10,000 Other _____ Automatic Premium Loan provision (if available) ☐ Yes ☐ No	Face Amount: ☐ $5,000 ☐ $7,000 ☐ $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

1. List below all life insurance policies and/or annuity contracts that have terminated in the last 13 months, are now inforce (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 box:** ☐ None
2. 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

SECTION 8: 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 more than one type of coverage in addition to your Medicare benefits.
- 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 a telephone interview may be necessary to verify or supplement information given to the Company on this application. 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 may be 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 to the best of my knowledge and belief. I understand that the 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 and accepted, each applicant will receive a separate policy; (b) my policy benefits start no earlier than my Medicare effective date; (c) the first full premium has been paid according to the mode of payment specified in the application, and (d) 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 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)

SECTION 9: AGENT SUPPLEMENT

List any other health insurance policies/certificates you have sold to the applicant.

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

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 inforce.

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

SECTION FOR ADDITIONAL COMMENTS

APPLICANT (please attach a separate sheet if needed)	**APPLICANT B** (please attach a separate sheet if needed)

Definitions of Eligible Person for Guaranteed Issue and Creditable Coverage

Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(a) The certification of the organization or plan has been terminated; or

(b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851 (g)(3)(B) of the Social Security Act (where the behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

(d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

1. The organization offering the plan substantially violated a material provision of the organization's contract under U.S.C Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered case in accordance with applicable quality standards; or
2. The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(e) The individual meets such other exceptional conditions as the Secretary may provide.

(3) The individual is enrolled with an entity listed in subparagraphs (A) – (D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) of this subsection:

(a) An eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost)'

(b) A similar organization operating under a contract under demonstration project authority, effective for periods before April 1, 1999;

(c) An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or

(d) An organization under a Medicare Select policy; and

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

(a) Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of involuntary termination of coverage or enrollment under the policy;

(b) The issuer of the policy is substantially violated a material provision of the policy; or

(c) The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or

(6) The individual, upon first becoming enrolled in Medicare part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

(7) The Individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that cover outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D with the application for a policy described in subsection (c)(4) of this section.

(8) The individual loses eligibility for health benefits under Medicaid.

Creditable Coverage means (a) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); (b) a group health benefit plan provided by a health insurance carrier or an HMO; (c) an individual health insurance certificate or evidence of coverage; (d) Part A or Part B of Title XVIII of the Social Security Act; (e) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (f) Chapter 55 of Title 10 (CHAMPUS); (g) a medical care program of the Indian Health Service or of a tribal organization; (h) a state or political subdivision health benefits risk pool; (i) a health plan offered under Chapter 89 of Title 5 (Federal Employees Health Benefits Program); (j) a public health plan (as defined in federal regulation); (k) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)); or (l) short-term limited duration insurance.

Sentinel Security Life Insurance Company
PO Box 27248 Salt Lake City, UT 84127-0248
1-800-247-1423

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) obtaining reinsurance; 3) determining or fulfilling responsibility for coverage and provision of benefits; 4) and administering coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, MIB, Inc., 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 its assigns as necessary 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 authorize Sentinel Security Life Insurance Company, or its reinsurers, to make a brief report of my protected personal health information to MIB, Inc.

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

RETURN TO COMPANY

MEDICARE SUPPLEMENT REPLACEMENT

PO Box 27248 Salt Lake City, UT 84127-0248 • Toll Free 800-247-1423 • Fax 888-433-4795

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. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration and acceptance by the replacing insurer, 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 OR 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 reasons:

- ☐ Additional benefits.
- ☐ Same 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) 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 inforce. 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	

RETURN TO COMPANY

MEDICARE SUPPLEMENT REPLACEMENT

PO Box 27248 Salt Lake City, UT 84127-0248 • Toll Free 800-247-1423 • Fax 888-433-4795

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- ☐ Additional benefits.
- ☐ Same 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) 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 inforce. 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	

LEAVE WITH APPLICANT

AGENT CERTIFICATION

I the undersigned insurance agent certify; **THAT,** I have taken an application for:

Primary Insured:

Medicare Supplement	Medicare Select
☐ **Plan A**	☐ **Plan C***
☐ **Plan B**	☐ **Plan D**
☐ **Plan C***	☐ **Plan F***
☐ **Plan D**	☐ **Plan N**
☐ **Plan F***	
☐ **Plan G**	
☐ **Plan N**	

Spouse:

Medicare Supplement	Medicare Select
☐ **Plan A**	☐ **Plan C***
☐ **Plan B**	☐ **Plan D**
☐ **Plan C***	☐ **Plan F***
☐ **Plan D**	☐ **Plan N**
☐ **Plan F***	
☐ **Plan G**	
☐ **Plan N**	

*Plan C or F is only available for those first eligible prior to January 1, 2020

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 ☐ 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

RETURN TO COMPANY

PO Box 27248 Salt Lake City, UT 84127-0248 • Toll Free 800-247-1423 • Fax 888-433-4795

NEW VANTAGE® I
FINAL EXPENSE LIFE INSURANCE

The New Vantage® I is a whole life insurance product designed to help cover final expenses such as the costs associated with funeral and burial expenses. The New Vantage® I plan provides guaranteed, level premiums and uses the same simplified application as the Sentinel Medicare Supplement plans.

- New Vantage® I pays the full death benefit in all years.
- Minimum Face Amount - $1,000
- Minimum Premium - $10 Monthly
- Maximum Face Amount: (use age last birthday):
  - Ages 0-75 - $35,000
  - Ages 76-80 - $25,000
  - Ages 81-85 - $15,000
- Policy is rated on age last birthday – no backdating to save age.
- Please refer to the New Vantage® I Height and Weight Chart for eligibility.
- Monthly Bank Draft Premiums are displayed on the rate chart.
  - Other modal premiums available are Quarterly, Semi-Annual and Annual.
  - Modal Premium must be the same as the Medicare Supplement modal premium.
- Underwriting Classes are Tobacco and Non-Tobacco.
  - Any tobacco product use within the last 12 months is considered to be a smoker.
  - Cigar or Pipe use once a week or less is considered to be a non-smoker.
- One check for both Medicare Supplement and Life policies is acceptable.
- Rate Calculation Form must be completed and submitted with application.

Please advise your client that a phone interview will be conducted within the next few days so they will be prepared to receive the call.

This is only a brief description of the policy guidelines. Please refer additional questions to your marketing representative.

PO Box 27248 Salt Lake City, UT 84127-0248 • Toll Free 800-247-1423 • Fax 888-433-4795

REV 1/1/14

MALE											FEMALE									
$10,000		$7,000		$5,000		$2,000		$1,000		Issue Age	$10,000		$5,000		$7,000		$2,000		$1,000	
NT	T	NT	T	NT	T	NT	T	NT	T		NT	T	NT	T	NT	T	NT	T	NT	T
53.82	76.34	38.58	54.34	28.41	39.68	13.17	17.68	8.09	10.34	65	42.42	55.70	22.72	29.36	30.60	39.89	10.89	13.55	6.95	8.28
56.82	80.54	40.68	57.28	29.92	41.77	13.77	18.52	8.39	10.76	66	44.26	57.45	23.64	30.23	31.89	41.12	11.26	13.90	7.14	8.45
59.85	85.48	42.80	60.74	31.43	44.25	14.38	19.50	8.69	11.26	67	46.10	60.70	24.55	31.85	33.17	43.39	11.63	14.55	7.32	8.78
63.20	90.70	45.14	64.40	33.11	46.86	15.05	20.55	9.03	11.78	68	48.29	63.61	25.65	33.31	34.71	45.43	12.07	15.13	7.54	9.07
66.26	96.07	47.29	68.15	34.64	49.54	15.66	21.62	9.34	12.32	69	50.68	66.50	26.84	34.76	36.38	47.46	12.54	15.71	7.78	9.36
69.93	101.98	49.85	72.29	36.47	52.49	16.39	22.80	9.70	12.91	70	53.12	69.87	28.07	36.44	38.09	49.81	13.03	16.38	8.02	9.70
75.43	108.43	53.70	76.80	39.22	55.72	17.49	24.09	10.25	13.55	71	56.18	74.51	29.59	38.76	40.23	53.06	13.64	17.31	8.33	10.16
80.93	117.60	57.55	83.22	41.97	60.30	18.59	25.93	10.80	14.47	72	60.32	79.09	31.67	41.05	43.13	56.27	14.47	18.23	8.74	10.62
86.43	126.76	61.40	89.64	44.72	64.89	19.69	27.76	11.35	15.39	73	64.43	84.60	33.72	43.80	46.00	60.12	15.29	19.33	9.15	11.17
91.93	135.93	65.25	96.06	47.47	69.47	20.79	29.59	11.90	16.30	74	69.01	90.93	36.01	46.97	49.21	64.55	16.21	20.59	9.61	11.80
97.43	148.19	69.10	104.63	50.22	75.60	21.89	32.05	12.45	17.53	75	76.34	99.50	39.68	51.26	54.34	70.55	17.68	22.31	10.34	12.66
108.45	163.19	76.82	115.13	55.73	83.10	24.10	35.05	13.55	19.03	76	81.66	107.22	42.33	55.12	58.06	75.96	18.74	23.85	10.87	13.43
119.76	174.83	84.74	123.28	61.39	88.92	26.36	37.37	14.69	20.19	77	87.51	115.90	45.26	59.46	62.16	82.03	19.91	25.59	11.46	14.30
129.41	186.54	91.49	131.48	66.21	94.78	28.29	39.72	15.65	21.36	78	94.06	123.63	48.53	63.32	66.74	87.44	21.22	27.13	12.11	15.07
138.10	199.48	97.57	140.54	70.55	101.24	30.03	42.30	16.52	22.66	79	101.37	132.31	52.19	67.66	71.86	93.52	22.68	28.87	12.85	15.94
147.07	215.29	103.85	151.61	75.04	109.15	31.82	45.47	17.42	24.24	80	108.30	140.90	55.65	71.96	76.71	99.53	24.07	30.59	13.54	16.80
158.36	229.35	111.76	161.45	80.69	116.18	34.08	48.28	18.55	25.64	81	117.24	153.86	60.13	78.44	82.97	108.61	25.86	33.18	14.43	18.10
168.97	242.78	119.18	170.85	85.99	122.89	36.20	50.96	19.61	26.99	82	128.12	168.97	65.57	85.99	90.59	119.18	28.03	36.20	15.52	19.61
180.56	257.11	127.29	180.88	91.78	130.06	38.52	53.83	20.76	28.42	83	138.83	182.48	70.92	92.75	98.08	128.64	30.17	38.90	16.59	20.96
191.58	272.28	135.01	191.50	97.30	137.65	40.72	56.86	21.87	29.94	84	149.18	196.96	76.09	99.98	105.33	138.77	32.24	41.80	17.63	22.40
202.75	285.44	142.82	200.71	102.88	144.23	42.96	59.50	22.98	31.25	85	160.85	211.43	81.93	107.22	113.50	148.90	34.58	44.69	18.79	23.85

NOTES:
1. For face amounts not listed, please refer to the New Vantage Life Rate & Underwriting Guide (FORM #SSLNVRATES)
2. Rates are pre-calculated, monthly, ACP rates including $35 policy fee
3. To calculate other payment frequency premiums, please refer to the New Vantage Life Rate & Underwriting Guide (FORM #SSLNVRATES)

CALCULATE YOUR PREMIUM

Calculate Your Premium *Medicare Supplement*

Medicare Supplement Plan

Before you begin: If you are 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 l Life*

TO ADD NEW VANTAGE I LIFE INSURANCE

For total face amounts other than $1,000, $2,000, $5,000, $7,000 or $10,000, or for modes other than monthly, refer to the Rate and Underwriting Guide.			Applicant's Premium Calculation	Spouse's Premium Calculation
Choose the base face amount of life insurance you want to purchase ($1,000, $2,000, $5,000, $7,000 or $10,000)	Base Face Amount $ 5,000 (Example based on Male age 75 non-smoker)	Premium Amount $50.22		
Add the Medicare Supplement (from top section) and Life Insurance premiums (this section) together	$153.52 (Med Supp) + $ 50.22 (Life Ins) = $203.74	One check payable to Sentinel Security Life for $203.74		

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 are sorry, you are 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
Height	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

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased, and in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision, and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an inforce illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Applicant B's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

RETURN TO HOME OFFICE

IMPORTANT NOTICE:
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

This document must be signed by the applicant and the producer, if there is one, and a copy left with the applicant.

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A replacement occurs when a new policy or contract is purchased, and in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision, and ask that you answer the following questions and consider the questions on the back of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? ___ YES ___ NO

2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? ___ YES ___ NO

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.			
2.			
3.			

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. If you request one, an inforce illustration, policy summary or available disclosure documents must be sent to you by the existing insurer. Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because _____

I certify that the responses herein are, to the best of my knowledge, accurate:

_____ _____
Applicant's Signature and Printed Name Date

_____ _____
Applicant B's Signature and Printed Name Date

_____ _____
Producer's Signature and Printed Name Date

I do not want this notice read aloud to me. _____ (Applicants must initial only if they do not want the notice read aloud.)

LEAVE WITH APPLICANT

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:
Are they affordable?
Could they change?
You're older—are premiums higher for the proposed new policy?
How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:
New policies usually take longer to build cash value and to pay dividends.
Acquisition costs for the old policy may have been paid, you will incur costs for the new one.
What surrender charges do the policies have?
What expense and sales charges will you pay on the new policy?
Does the new policy provide more insurance coverage?

INSURABILITY:
If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.
You may need a medical exam for a new policy.
Claims on most new policies for up to the first two years can be denied based on inaccurate statements.
Suicide limitations may begin anew on the new coverage.

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?
How will the premiums on your existing policy be affected?
Will a loan be deducted from death benefits?
What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?
What are the interest rate guarantees for the new contract?
Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?
Is this a tax free exchange? (See your tax advisor.)
Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?
Will the existing insurer be willing to modify the old policy?
How does the quality and financial stability of the new company compare with your existing company?

LEAVE WITH APPLICANT

Sentinel Security Life Insurance Company
PO Box 27248 Salt Lake City, UT 84127-0248
1-800-247-1423

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, PO Box 27248 Salt Lake City, UT 84127.

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 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 (the 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

LEAVE WITH APPLICANT

MEDICARE SELECT DISCLOSURE STATEMENT

PO Box 27248 Salt Lake City, UT 84127-0248 • Toll Free 800-247-1423 • Fax 888-433-4795

UNDERSTANDING MEDICARE SELECT

Offered and underwritten by Sentinel Security Life Insurance Company. Medicare SELECT supplement insurance plans offer attractive premiums in exchange for your commitment to use Network Hospitals whenever possible.

Only certain Hospitals are network providers under this policy. Check with your Physician to determine if he or she has admitting privileges at the Network Hospital. If he or she does not, You may be required to use another Physician at time of hospitalization or You will be required to pay all expenses.

NETWORK HOSPITAL RESTRICTIONS

When you require health care services in a Hospital on an inpatient basis, you may choose any Hospital you wish. However, benefits under the Inpatient Hospital Confinement Deductible Benefit provision are conditioned on whether you use a Participating Hospital or a Non-Participating Hospital. If you use the services of a Participating Hospital, the Medicare Part A inpatient Hospital deductible amount will be waived by the Hospital. If you use the services of a Non-Participating Hospital, the Hospital will not waive, and we will not pay, the Medicare Part A inpatient Hospital deductible amount, unless:

(1) you are hospitalized for symptoms requiring Emergency Care or hospitalization is immediately required for an unforeseen Sickness, Injury or condition;
(2) it is not reasonable for you to obtain services through a Participating Hospital; or
(3) you require covered services that are not available through a Participating Hospital.

These Network Hospital Restrictions apply only to the Inpatient Hospital Confinement Deductible Benefit. These restrictions do not apply to any other benefit in your policy.

We do not supervise, control or guarantee the health care services of any Hospital, whether it is a Participating Hospital or a Non-Participating Hospital.

EMERGENCY CARE

Benefits will be paid at any Medicare-approved hospital when you require emergency care and it is not reasonable to obtain such care from a network hospital.

Emergency Care means bona fide emergency services provided after the sudden onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in:

(1) placing the patient's health in serious jeopardy;
(2) serious impairment to bodily functions; or
(3) serious dysfunction of any bodily organ or part.

Emergency Care is available twenty-four (24) hours per day and seven (7) days per week.

REFERRALS

There are no restrictions on referrals to other hospitals if you obtain prior certification from your Physician or health care provider that the services are not available at a Network Hospital. Additionally, there are no restrictions on referrals for outpatient providers regardless of whether that provider is in the service area.

AVAILABILITY OF OTHER MEDICARE SUPPLEMENT PLANS

Sentinel Security Life Insurance Company offers Medicare Supplement Plans A, B, C, D, F, G and N. Any of these plans are available for you to purchase now or at any time you wish to convert from a Medicare SELECT plan. You also have the right (but are not required) to convert to any Medicare Supplement policy Sentinel Security Life has available with comparable or lesser benefits if (1) the Medicare SELECT program is discontinued, or (2) THE AGREEMENTS BETWEEN Sentinel Security Life and all Network Hospitals in your service area are terminated. A Medicare supplement policy will be considered to provide comparable or lesser benefits unless it contains one or more significant benefits not included in this Medicare Select Policy. For purposes of this provision, a significant benefit means coverage for the Medicare Part A deductible or coverage for Part B excess charges.

You may also convert your policy if you move outside the Service Area and your new residence is not within a reasonable travel distance of a Network Hospital. Although you are not requried to convert your policy in this instance, you will be responsible for Payment of the Medicare Part A inpatient Hospital deductible if you use a Non-Network Hospital for scheduled admissions.

If you choose to convert your policy to a Medicare Supplement policy, you will not need to provide evidence of insurability if your policy has been inforce for at least six (6) months.

LEAVE WITH APPLICANT

MEDICARE SELECT DISCLOSURE STATEMENT

PO Box 27248 Salt Lake City, UT 84127-0248 • Toll Free 800-247-1423 • Fax 888-433-4795

QUALITY ASSURANCE

Each Network Hospital within the Service Area has appropriate state licensing and is Medicare certified. All hospitals within the network have an appropriate mix of physician specialties for covered services provided by the hospital. When using a Network Hospital you're assured that the care you receive meets or exceeds the acceptable standards of quality for the hospital industry.

GRIEVANCE PROCEDURE

Sentinel Security Life strives to provide quality administration and services to you through an excellent customer service program designed to provide information to you, handle complaints and attempt to satisfy your concerns. You are encouraged to bring complaints to Our attention by contacting Sentinel Security Life's Customer Service program in writing: P.O. Box 27248, Salt Lake City, UT 84127-0248; or telephone 1-800-247-1423.

For settlement of disputes that have not been successfully resolved through Sentinel Security Life's customer service program, or that you desire to have settled by means of a written Grievance, the following formal Grievance procedures have been established.

If while staying at a Network Hospital, you have a complaint regarding hospital services being provided, you may contact Sentinel Security Life by phone (1-800-247-1423) to express the complaint. We will relay the complaint to the Network Hospital's Administration on an immediate basis for prompt resolution.

The following Grievance Procedures are designed to achieve mutual agreement for settlement of disputes:

(1) Any Grievance between you and us or between you and a hospital must be dealt with through this grievance procedure. Out-of hospital Grievances will be addressed immediately and resolved as soon as possible. You should write to us within 60 days of the date you are notified of any adverse action with respect to an out-of-hospital grievance. In-hospital Grievances relating to ongoing hospital treatment will be addressed immediately on receipt of any written or oral Grievance and will be resolved as quickly as possible in a manner which does not interfere with, obstruct or interrupt your continued medical treatment and care.

(2) Any written grievance must contain the words "THIS IS A GRIEVANCE" or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure.

(3) A grievance must be filed by submitting the complete details in writing to Sentinel Security Life Insurance Company, c/o Grievance Review, P.O. Box 27248, Salt Lake City, UT 84127-0248.

(4) Each grievance is processed within a maximum of 60 days after it is received by us. Each level of the grievance process is handled by a person with problem-solving authority. A Physician, other than your primary care physician, must be involved in reviewing any medically related grievances.

(5) If a grievance is found to be valid, corrective action will be taken promptly.

(6) All concerned parties are to be notified about the result of a grievance.

(7) You have the right to appeal to the Department of Insurance after first completing our grievance process.

(8) Any meeting with you must be scheduled at a location or in a manner which is convenient and will not necessitate excessive travel or undue hardship.

In order to help you evaluate the benefits in each Medicare SELECT and Medicare Supplement policy Sentinel Security Life offers; please review the appropriate Outline of Coverage.

LEAVE WITH APPLICANT

ACKNOWLEDGEMENT OF RECEIPT OF MEDICARE SELECT DISCLOSURE STATEMENT

PO Box 27248 Salt Lake City, UT 84127-0248 • Toll Free 800-247-1423 • Fax 888-433-4795

I, the applicant, acknowledge receipt of the following information:

- ☐ Outline of Coverage and Premium Information for the Medicare SELECT Plan for which I am applying;
- ☐ Description of Network Hospitals; and
- ☐ Medicare SELECT Disclosure Statement.

I also understand the following:

- ☐ The Part "A" benefits of the Sentinel Security Life Medicare SELECT plan may be restricted if I receive services in a hospital that is not a Network Provider.
- ☐ Sentinel Security Life Insurance Company does not advise the purchase of a Medicare SELECT policy if I live more than a reasonable distance for me to travel to receive inpatient health services as reflected by usual and customary travel patterns of my area from the Network Hospital; unless the Network Hospital is the closest hopital to me which offers this level of service.
- ☐ I have the right to purchase any non-restricted Medicare Supplement insurance product offered by Sentinel Security Life Insurance Company.

I acknowledge receipt of the above information and I understand the information above including the restrictions of the Medicare SELECT Plan.

Applicant's Signature _____ **Date** _____

RETURN TO COMPANY

ACH FAX TRANSMITTAL GUIDE

Initial Premiums Paid through ACH (Automated Clearing House) Medicare Supplement / Life applications may have their initial premium automatically deducted from their checking or savings account through the specific Electronic Funds Transfer (EFT) process. When they do, you may fax the application and required forms instead of mailing them.

Follow these easy steps to submit Medicare Supplement / Life applications using ACH for the initial premium:

STEP 1 – COMPLETE THE AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER SECTION ON THE APPLICATION.

Applicants wishing to pay electronically complete the appropriate Medicare Supplement / Life Authorization for Electronic Funds Transfer section on the application.

STEP 2 – FAX THE FOLLOWING ITEMS TO THE DEDICATED LINE FOR ACH PAYMENTS AT (888) 433-4795

1) ACH fax transmittal cover sheet on the back of this form

2) Medicare Supplement / Life Application and other required forms including authorization for EFT

If you fax the application, do not mail it as processing errors occur and additional charges could result in the duplication.

For agent use only. Not for use with the general public.

ACH FAX TRANSMITTAL

FAX TRANSMITTAL

FOR USE WITH EFT MONTHLY PREMIUM APPLICATIONS ONLY

1-888-433-4795

Use this fax number only for applications and new business documents. Applications faxed to any other number can cause delays in processing your business.

Please complete the following information:

Total number of pages being faxed including this cover sheet _____

Agent Name _____

Agent Number _____

Agent Phone Number / Agent Fax Number _____

Comments _____

This communication and any attachments transmitted with it are confidential and are solely for the use of the addressee. It may contain material that is legally privileged, proprietary or subject to copyright belonging to Sentinel Security Life Insurance Company and its affiliates. It may be subject to protection under federal or state law. If you are not the intended recipient, you are notified that any use of this material is strictly prohibited. If you received this transmission in error, please contact the sender immediately by telephone, at the number shown above. We will arrange for you to return the original material to us via the US Postal Service and if requested, we will reimburse you for such expense.

NOTES

Sentinel Security Life Insurance Company

Since 1948, families have counted on Sentinel Security Life Insurance Company during their time of need. The Company was originally established to provide families a way of funding funeral expenses and burial costs. Through our final expense life insurance product, we have been honored to provide peace of mind to families for well over half a century.

Today, Sentinel offers a strong senior market portfolio including Life, Medicare Supplement and Annuity products. We continue to develop new products while improving existing products and services to better protect our customers.

Sentinel has a long history of financial strength and stability that has afforded us the opportunity to invest wisely in the growth of our company. Our strength lies not only in the quality of our insurance products, but also the level of service we provide to our policyholders, agents, and shareholders. We invite you to learn more about our company by visiting www.sslco.com or by calling 800-247-1423.

SENTINEL SECURITY LIFE INSURANCE COMPANY
PO BOX 27248 SALT LAKE CITY, UTAH 84127-0248