Sentry Life Insurance Company
Group Administration F3/52
P.O. Box 8024
Stevens Point, WI 54481-8024

SENTRY®
LIFE INSURANCE
COMPANY

Employer _____

Address _____

_____

Policy No. _____

Termination Date or _____
Date of Divorce (if applicable)

Length of Continuation _____
(if applicable)

Employee Name _____ Date Completed _____

Name of Person
Continuing _____ Date of Birth _____
(if other than employee) ☐ Spouse ☐ Child

Address _____

_____

_____

Continuation of Coverage Status

☐ Single ☐ Employee/Spouse

☐ Employee/Child(ren) ☐ Family

When your group dental coverage terminates, you may have an option to continue coverage. Also, when your spouse's coverage terminates due to divorce, your spouse's coverage under the group policy may be continued. Your certificate describes the conditions under which continued coverage can be obtained.

DENTAL COVERAGE CONTINUATION REQUEST

This notice will serve as notification of the right to continue dental expense care coverage, entirely at your own expense, under this firm's group policy. The certificate describes the terms under which coverage may be continued.

To retain this coverage, you may pay $_____ monthly, by check or money order. It must be made payable to _____ (employer), and received by the employer by the _____ day of each month. The first payment is to be made on or before _____. Failure to make timely payment will result in the termination of coverage.

Any change in benefits or premium occurring during the period of continued coverage will be reflected in your monthly payment. The above employer will notify you of any changes.

Check One: ☐ Yes – I do wish to continue my dental coverage.

☐ No – I do not wish to continue my dental coverage.

_____ _____

Date Continued Person's Signature

*(Does not include Life or Disability Income coverage)