EMPLOYEE APPLICATION

SENTRY® LIFE INSURANCE COMPANY

IMPORTANT NOTICE - KEEP FOR YOUR RECORDS

FOR YOUR PROTECTION, CALIFORNIA LAW REQUIRES THE FOLLOWING TO APPEAR ON THIS FORM. Any person who knowingly presents false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

In order to fairly evaluate your application, we may consult various sources including:

- Statements you make on your application
- Your Employer
- Reports from doctors or medical facilities
- MIB, Inc.

Information regarding your insurability will be treated as confidential. It will not be released without your authorization except as follows:

- To your doctor if there is a condition you may not be aware of
- To Sentry employees, re-insurers or affiliates when needed to handle your insurance
- As required by law
- To law enforcement when illegal activities are suspected

Sentry Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., 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, Inc. member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file.

Upon receipt of a request from you, MIB, Inc. will arrange disclosure of any information it may have in your file. Please contact MIB, Inc. at 866-692-6901. If you question the accuracy of information in the MIB, Inc. file, you may contact MIB, Inc. and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of the MIB, Inc. information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

Sentry Life Insurance Company, or its reinsurers, may also release information in 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.

Medical information will be disclosed only through your doctor.

You may learn the nature of any information Sentry has in its file and how any incorrect information may be corrected by contacting the Office of Consumer Affairs, 1800 North Point Drive, Stevens Point, WI 54481.

NOTICE CONCERNING STATEMENTS IN THE EMPLOYEE APPLICATION FOR YOUR INSURANCE

Please read this Application. Omissions or misstatements may cause an otherwise valid claim to be denied. Insurance will be issued on the basis that all the information shown is correct and true.

Sentry Life Insurance Company • 1800 North Point Drive • Stevens Point, Wisconsin 54481

EMPLOYEE APPLICATION

(Please Print-Use Ink)

Send completed original application to:
Sentry Life Insurance Company
1800 North Point Drive
P.O. Box 8024
Stevens Point, WI 54481

SENTRY® LIFE INSURANCE COMPANY

Account Number: _____	Check all that apply: ☐ Initial Enrollment ☐ Add Spouse/Registered Domestic Partner* ☐ Add Dependent Child* ☐ Name Change* ☐ Other: _____ *Provide information in the section below titled "List all eligible Dependents."

Employer Name	Address, City, State, Zip

Employee First Name, Middle Initial and Last Name	Address, City, State, Zip

Date of Birth	Place of Birth	☐ Male ☐ Female ☐ Single ☐ Married and Date of Marriage: ___/___/___
Social Security Number		Phone Number
Number of Hours Worked per Week for this Employer		Occupation with this Employer
Date of Permanent Full-Time Employment with this Employer		Indicate Annual Salary $_____

Indicate the coverage you are applying for:

☐ Life and AD&D ☐ Short Term Disability ☐ Long Term Disability ☐ _____

☐ Dental - Employee ☐ Dental - Employee/Spouse or Registered Domestic Partner ☐ Dental - Employee/Child(ren) ☐ Dental - Family

List all eligible Dependents - This section is applicable to Dental and/or Dependents Life coverage.

First Name, Middle Initial and Last Name	Relationship	Date of Birth	Social Security Number

Sentry's Use Only	Base Life Class Amt. $ Deps. Life ☐ Y ☐ N	Opt. Life Class Amt. $	STD Class Amt. $	LTD Class Amt. $	Dental Class ☐ sgl ☐ eco ☐ eso ☐ family	PID # Effective Date Initial Date
	☐ Non-Med ☐ Med	☐ Non-Med ☐ Med	☐ Non-Med ☐ Med	☐ Non-Med ☐ Med	☐ Non-Med ☐ Late	

Primary Beneficiary

Name (First, Middle Initial, Last)	Relationship
Social Security Number	Date of Birth
Address, City, State, Zip	Phone Number

If the beneficiary is a trust, complete the applicable fields with the trust information and include the date of trust in the date of birth field.

Note: If you designate two or more beneficiaries, they will share equally in the benefits unless you indicate other directions.

Contingent Beneficiary (Contingent Beneficiaries are only applicable if all primary beneficiaries are deceased.)

Name (First, Middle Initial, Last)	Relationship
Social Security Number	Date of Birth
Address, City, State, Zip	Phone Number

If the beneficiary is a trust, complete the applicable fields with the trust information and include the date of trust in the date of birth field.

Note: If you designate two or more beneficiaries, they will share equally in the benefits unless you indicate other directions.

ACCEPT

Information provided on this application is given to obtain insurance coverage selected and is true and complete to the best of my knowledge. I understand this application will be processed through my employer or group policyholder, or its administrator. I authorize Sentry Life Insurance Company to disclose any information contained in this application, including any health information, to my employer or group policyholder, or its administrator, in connection with the application, underwriting and administration of the coverage. This authorization to disclose information is valid for two (2) years from the date this application is signed. I understand that I may revoke this authorization at any time by writing to Sentry Life Insurance Company, 1800 North Point Drive, Stevens Point, WI 54481. Any information disclosed prior to receipt of the revocation will not be affected. I understand my medical records and information which is Protected Health Information governed by the Health Insurance Portability and Accountability Act, once disclosed to others, may be redisclosed by the recipients and is no longer protected by that Act or the underlying privacy regulations. I authorize release of my health-related information by any licensed doctor, medical practitioner or other health care provider, any hospital, clinic or other health-care facility, any insurance or reinsurance company, pharmacy or the MIB, Inc. to determine my eligibility for insurance. I understand that the insurance applied for will not be in force unless Sentry Life Insurance Company approves this application. I have received and read the Important Notice required by the Fair Credit Reporting Act and MIB, Inc. I know that I or my authorized representative is entitled to receive a copy of this authorization.

Employee Signature: _____ **Date:** _____

PRINT EMPLOYEE NAME _____

EMPLOYER NAME _____

WAIVER	
	I have been given a chance to enroll in the insurance plans through my employer with Sentry. However, I decline to enroll for _____. If I apply for this insurance at a later date, I understand that I must furnish, at my own expense, proof of good health. Sentry reserves the right to reject my application. Employee Signature: _____ Date: _____ PRINT EMPLOYEE NAME _____ EMPLOYER NAME _____

Complete this Page When Evidence of Insurability is Required
Please Initial and Date Any Changed Answers

1) Primary Physician Name: _____ ☐ None
Physician Address: _____
Date of your last visit: _____ Reason/Diagnosis last seen: _____

2) What is your height? _____ Weight? _____

		YES	NO
3)	To the best of your knowledge, have you, during the last five years, been treated or examined by any physician or other medical or psychiatric practitioner? Give details below.	☐	☐
4)	To the best of your knowledge, have you, during the last five years, undergone any surgical operation or been confined or treated in any hospital, sanitarium or other medical or psychiatric institutions for treatment or rehabilitation?	☐	☐
5)	To the best of your knowledge, in the last four years, have you been treated by a member of the medical profession for: chest pain, heart trouble, high blood pressure, diabetes, cancer, tumor, ulcer, emphysema, asthma, shortness of breath, stroke, sleep apnea, alcoholism, drug abuse, or mental or nervous disorder? (If "YES", underline disease and give details below.)	☐	☐
6)	To the best of your knowledge, do you take any prescription medications? Give details below.	☐	☐
7)	To the best of your knowledge, are you planning, have a doctor's recommendation for, or in need of a surgical operation, laboratory testing or radiology services for diagnostic purposes, hospitalization, or any other treatment?	☐	☐
8)	To the best of your knowledge, are you now pregnant? (If "YES", due date _____) Complications or problems with current or past pregnancies: _____	☐	☐
9)	To the best of your knowledge, in the last ten years, have you been diagnosed or treated for chronic or recurrent fever, fatigue or viral illness, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **Please note: Question 9 is not asking about results of any HIV testing. In addition, California law prohibits an HIV test from being required or used by insurance companies as a condition of obtaining insurance coverage.**	☐	☐

10) Complete details below (or on an additional signed and dated page) to all questions answered yes:

Question Number	Indicate Illness or Nature of Complaint/Treatment or Medication	Duration From: To:	Current Status	Names & Complete Addresses of Physicians, Hospitals and Clinics

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I AUTHORIZE Sentry Life Insurance Company, its reinsurers or legal representatives to obtain medical information about me for the limited purpose of verifying the accuracy and completeness of the information provided in this application and determining my acceptability for the insurance coverage selected and to make a brief report of my protected health information to MIB, Inc. I authorize release of my health-related information by any licensed doctor, medical practitioner or other health care provider, any hospital, clinic or other health-care facility, any insurance or reinsurance company, pharmacy or the MIB, Inc. to determine my eligibility for insurance. This authorization to disclose information is valid for two (2) years from the date this application is signed.

I AGREE THAT: All statements on this application are true to the best of my knowledge and belief. This Authorization is valid for two years from the date below. A copy or fax of this Authorization is as valid as the original.

Employee Signature: _____ **Date:** _____

PRINT EMPLOYEE NAME: _____ EMPLOYER NAME: _____