EMPLOYEE APPLICATION

Account Number: _____

Sentry Life Insurance Company
1800 North Point Drive
P.O. Box 8024
Stevens Point, WI 54481

SENTRY® LIFE INSURANCE COMPANY

☐ Initial Enrollment	Change - Check all that apply: ☐ Add Spouse* ☐ Add Dependent Child* ☐ Name Change* ☐ Other: _____ *Provide information in the section below titled "List all eligible Dependents." Do not use this form to change a beneficiary. Please complete a change of beneficiary form.

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 ☐ 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, to my employer or group policyholder, or its administrator, in connection with the application 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.

ANY PERSON WHO KNOWINGLY AND WITH INTENT TO INJURE, DEFRAUD, OR DECEIVE ANY INSURER FILES A STATEMENT OF CLAIM OR AN APPLICATION CONTAINING ANY FALSE, INCOMPLETE, OR MISLEADING INFORMATION IS GUILTY OF A FELONY OF THE THIRD DEGREE.

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 _____

AUTHORIZATION TO RELEASE INFORMATION

Sentry will treat this information as confidential. It will not be released without your authorization except as follows:

- 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.

I KNOW THAT: My application will be processed through my employer, group policyholder or its administrator. Statements made on this application and action taken regarding it will be available to my employer, group policyholder or administrator. Statements made in the application are representations and not warranties.

Employee Signature: _____ **Date:** _____

PRINT EMPLOYEE NAME: _____ EMPLOYER NAME: _____