EMPLOYEE APPLICATION

SENTRY® LIFE INSURANCE COMPANY

IMPORTANT NOTICE - KEEP FOR YOUR RECORDS

IT IS A CRIME TO KNOWINGLY PROVIDE FALSE, INCOMPLETE OR MISLEADING INFORMATION TO AN INSURANCE COMPANY FOR THE PURPOSE OF DEFRAUDING THE COMPANY. PENALTIES MAY INCLUDE IMPRISONMENT, FINES OR A DENIAL OF INSURANCE BENEFITS.

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.

NOTICE APPLICABLE TO LONG TERM DISABILITY INSURANCE

The Group Policy contains exclusions, limitations and reductions in coverage with Other Income Benefits for which you or your dependents may be eligible. Please carefully read the Group Insurance Certificate you will receive when you become insured for a complete description of coverage and all defined terms.

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

EMPLOYEE APPLICATION
(Please Print-Use Ink)

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	Opt. Life	STD	LTD	Dental	PID #
	Class Amt. $ Deps. Life ☐ Y ☐ N	Class Amt. $	Class Amt. $	Class Amt. $	Class ☐ sgl ☐ eco ☐ eso ☐ family	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

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. I understand that if I revoke this authorization, it may impair Sentry's ability to evaluate or process this application or any claim, and may be a basis for denying this application or any claims for benefits. 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. **This authorization excludes divulging whether tests for the presence of the HIV antibody have been performed and excludes divulging the results of those tests. Such test results may not be disclosed or published. Nothing will prohibit this authorization for divulging the fact that the applicant has AIDS/ARC.** 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. Failure to sign this authorization may impair Sentry's ability to evaluate or process this application or any claim, and may be a basis for denying this application or any claims for benefits. I know that I am 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 – Regarding questions 3, 4, 7 and 9, you may answer these questions "no" if you have tested positive for HIV but have not developed symptoms of the disease AIDS or ARC.

1) Primary Physician Name: ______________________________ ☐ None
Physician Address: ______________________________
Date of your last visit: __________ Reason/Diagnosis last seen **(excluding HIV):** ______________________________
____

2) What is your height? __________ Weight? __________

	YES	NO
3) Have you, during the last five years consulted, been treated or examined by any physician or other practitioner **(excluding HIV)**? Give details below.	☐	☐
4) Have you, during the last five years, undergone any surgical operation or been confined or treated in any hospital, sanitarium or similar institution **(excluding HIV)**?	☐	☐
5) Have you EVER had, been told you have or been treated 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) Do you take any medications? Give details below.	☐	☐
7) Are you contemplating a surgical operation, diagnostic testing, hospitalization, or any other treatment **(excluding HIV)**?	☐	☐
8) Are you now pregnant? (If "YES", due date ______________________________)	☐	☐
Complications or problems with current or past pregnancies: ______________________________		
9) Have you had, been told you had, or been treated for immune system disorders, Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? **Answer this question "NO" if you have tested positive for HIV but have not developed symptoms of the disease AIDS or ARC.**	☐	☐

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, or its 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 MIB, Inc., to determine the acceptability of this application as stated above. **This authorization excludes divulging whether tests for the presence of the HIV antibody have been performed and excludes divulging the results of those tests. Such test results may not be disclosed or published. Nothing will prohibit this authorization from divulging the fact that the applicant has AIDS/ARC.**

I KNOW that I am entitled to receive a copy of this authorization.

I AGREE that all statements and information in this application are true and Sentry, believing them to be true, may act accordingly. This Authorization and Release is valid for two years from the date below. A copy of fax of this Authorization and Release is as valid as the original. I understand that I may revoke this Authorization and Release at any time, or request a copy of this Authorization and Release, 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 that if I revoke this Authorization and Release, it may impair Sentry's ability to evaluate or process this application or any claim, and may be a basis for denying this application or any claims for benefits.

Failure to sign this Authorization to Obtain and Release Information may impair Sentry's ability to evaluate or process this application or any claim, and may be a basis for denying this application or any claims for benefits.

Employee Signature: ______________________________ **Date:** ______________

PRINT EMPLOYEE NAME: ____________________ EMPLOYER NAME: ____________________