

# EMPLOYEE APPLICATION



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## IMPORTANT NOTICE - KEEP FOR YOUR RECORDS

**Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.**

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: _____	Change - Check all that apply: <input type="checkbox"/> Initial Enrollment <input type="checkbox"/> Add Spouse* <input type="checkbox"/> Add Dependent Child* <input type="checkbox"/> Name Change* <input type="checkbox"/> 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.
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Employer Name	Address, City, State, Zip
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Employee First Name, Middle Initial and Last Name	Address, City, State, Zip
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Date of Birth	Place of Birth	<input type="checkbox"/> Male	<input type="checkbox"/> Female	<input type="checkbox"/> Single <input type="checkbox"/> Married and Date of Marriage: ____ / ____ / ____
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Social Security Number	Phone Number
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Number of Hours Worked per Week for this Employer	Occupation with this Employer
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Date of Permanent Full-Time Employment with this Employer	Indicate Annual Salary \$ _____
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**Indicate the coverage you are applying for:**

<input type="checkbox"/> Life and AD&D	<input type="checkbox"/> Short Term Disability	<input type="checkbox"/> Long Term Disability	<input type="checkbox"/> _____
<input type="checkbox"/> Dental - Employee	<input type="checkbox"/> Dental - Employee/Spouse	<input type="checkbox"/> Dental - Employee/Child(ren)	<input type="checkbox"/> 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	Class	Class	Class	Class	Effective Date
	Amt. \$	Amt. \$	Amt. \$	Amt. \$	Amt. \$	Initial Date
Dep's. Life <input type="checkbox"/> Y <input type="checkbox"/> N					<input type="checkbox"/> sgl <input type="checkbox"/> eco <input type="checkbox"/> eso <input type="checkbox"/> family	
<input type="checkbox"/> Non-Med <input type="checkbox"/> Med	<input type="checkbox"/> Non-Med <input type="checkbox"/> Med	<input type="checkbox"/> Non-Med <input type="checkbox"/> Med	<input type="checkbox"/> Non-Med <input type="checkbox"/> Med	<input type="checkbox"/> Non-Med <input type="checkbox"/> Med	<input type="checkbox"/> Non-Med <input type="checkbox"/> 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 30 months 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 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.

**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) Have you, during the last five years consulted, been treated or examined by any physician or other practitioner? Give details below.....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 4) Have you, during the last five years, undergone any surgical operation or been confined or treated in any hospital, sanitarium or similar institution? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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.)..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 6) Do you take any medications? Give details below. ....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 7) Are you contemplating a surgical operation, diagnostic testing, hospitalization, or any other treatment?.....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 8) Are you now pregnant? (If "YES", due date _____) .....<br>Complications or problems with current or past pregnancies: _____   | <input type="checkbox"/> | <input type="checkbox"/> |
| 9) In the last ten years, have you been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV)? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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 information about me and to make a brief report of my protected health information to MIB, Inc. Information may be obtained from any licensed doctor, medical practitioner, hospital, clinic or other medically related facility, insurance or reinsurance company, MIB, Inc. or others with knowledge relative to the above purposes. This information will be used to determine my eligibility for insurance.

I AGREE THAT: All statements on this application are true to the best of my knowledge and belief and Sentry, believing them to be true, shall act accordingly. This Authorization is valid for 30 months from the date this Authorization is signed. A copy or fax of this Authorization is as valid as the original.

**Employee Signature:** \_\_\_\_\_ **Date:** \_\_\_\_\_

PRINT EMPLOYEE NAME: \_\_\_\_\_ EMPLOYER NAME: \_\_\_\_\_