SENTRY LIFE INSURANCE COMPANY OF NEW YORK

Employee Application – Group Life, Accidental Death and Dismemberment, Disability and Dental Insurance

SENTRY® LIFE INSURANCE COMPANY OF NEW YORK

1-800-962-2922

IMPORTANT NOTICE - KEEP FOR YOUR RECORDS

THIS FRAUD WARNING DOES NOT APPLY TO LIFE INSURANCE. ANY PERSON WHO, KNOWINGLY AND WITH INTENT TO DEFRAUD ANY INSURANCE COMPANY OR OTHER PERSON FILES AN APPLICATION FOR INSURANCE OR STATEMENT OF CLAIM CONTAINING ANY MATERIALLY FALSE INFORMATION, OR CONCEALS FOR THE PURPOSE OF MISLEADING, INFORMATION CONCERNING ANY FACT MATERIAL THERETO, COMMITS A FRAUDULENT INSURANCE ACT, WHICH IS A CRIME, AND SHALL ALSO BE SUBJECT TO A CIVIL PENALTY NOT TO EXCEED FIVE THOUSAND DOLLARS AND THE STATED VALUE OF THE CLAIM FOR EACH SUCH VIOLATION.

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 and to you 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 or permitted by law.

Sentry 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 Post Office Box 105, Essex Station, Boston, Massachusetts 02112.

If you refused to authorize the procurement of information through MIB, Inc., your request for insurance may be declined.

Sentry, 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 Sentry Life Insurance Company of New York, 220 Salina Meadows Parkway, Suite 255, Syracuse, NY 13212.

NOTICE CONCERNING STATEMENTS IN THE EMPLOYEE APPLICATION FOR YOUR INSURANCE

Please read this Application. It is represented that the statements and answers are true and complete to the best of my knowledge and belief. It is agreed that all statements and answers will form the basis of any contract of insurance that may be used. Misstatements may cause an otherwise valid claim to be contested. All statements made are representations and not warranties. No statement made by any person insured under the policy shall be used to contest the insurance unless the statements made reflect a material misrepresentation and once the insurance has been in force for 2 years during such person's lifetime. Sentry may not contest the coverage unless a copy of the statement containing the alleged misrepresentation signed by the applicant has been provided to the applicant or his or her beneficiary.

Sentry Life Insurance Company of New York • 220 Salina Meadows Parkway • Suite 255
Syracuse • NY 13212

EMPLOYEE APPLICATION
(Please Print - Use ink or typewriter)

Account Number: _____

Sentry Life Insurance Company of New York
220 Salina Meadows Parkway Suite 255
Syracuse, NY 13212]
1-800-962-2922

☐ **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."

Employer Name	**Address, City, State, Zip**	**Phone #**

Employee Name	**Address, City, State, Zip**

Date of Birth / /	Place of Birth	☐ Male ☐ Female ☐ Single ☐ Married and Date of Marriage: / /

Social Security #	# of Hrs worked weekly for this Employer	Occupation with this Employer

Date of Permanent Full-Time employment with this Employer: / /	Indicate Annual Salary (Include commissions, exclude bonuses & overtime) $_____

Indicate the coverage you are applying for by placing an X in the appropriate box(es).

☐ Life and AD&D ☐ Long Term Disability ☐ _____
☐ Dental - Employee ☐ Dental - Employee/Spouse ☐ Dental - Employee/Child(ren) ☐ Dental - Family

Primary Beneficiary

_____ _____
Show full name, i.e., Helen A. Doe Relationship

Address _____

Social Security # _____

Phone # _____

Date of Birth: _____

Contingent Beneficiary

_____ _____
Name Relationship

Address _____

Social Security # _____

Phone # _____

Date of Birth: _____

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

Name (Last Name, First)	Relationship	Date of Birth	Social Security #

ACCEPT

Information provided on this application is given to obtain insurance coverage selected and is true and complete to the best of my knowledge and belief. I understand this application will be processed through my employer or group policyholder, or its administrator. I authorize Sentry 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 of New York, 220 Salina Meadows Parkway, Suite 255, Syracuse, NY 13212. Any information disclosed prior to receipt of the revocation will not be affected. I understand that the insurance applied for will not be in force unless Sentry Life Insurance Company of New York approves this application. I have received and read the Important Notice required by the Fair Credit Reporting Act and MIB, Inc.

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Employee Signature: _____ **Date:** _____

PRINT 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: _____

Sentry's Use Only

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

COMPLETE THIS PAGE WHEN EVIDENCE OF INSURABILITY IS REQUIRED.

HEALTH QUESTIONNAIRE – PLEASE INITIAL & DATE ANY CHANGED ANSWERS
If necessary, you may attach a sheet of paper to provide additional details for any question answered "Yes".

		YES	NO
1)	Have you ever been refused life insurance, any form of health insurance, or ever had a policy rated, modified or renewal refused?	☐	☐
2)	Have you, during the last five years consulted, been treated or examined by any physician or other Practitioner?	☐	☐
3)	Have you, during the last five years, undergone any surgical operation or been confined or treated in any hospital, sanitarium or similar institution?	☐	☐
4)	To the best of your knowledge and belief, have you EVER been treated for or been diagnosed as having: heart trouble, high blood pressure, sugar in urine, diabetes, tuberculosis, cancer, tumor, ulcer, emphysema, alcoholism, drug abuse, or mental or nervous disorder? (If "YES", underline disease)	☐	☐
5)	To the best of your knowledge and belief, are you now receiving any medical attention or surgical treatment or taking any medications?	☐	☐
6)	To the best of your knowledge and belief, are you now pregnant? (If "YES", due date _____)	☐	☐
7)	To the best of your knowledge and belief, have you had, been told you had, or been treated for Acquired Immune Deficiency Syndrome (AIDS) or AIDS-Related Complex (ARC)?	☐	☐
8)	To the best of your knowledge and belief, have you had, been told you had, or been treated for chronic or recurrent fever, fatigue or viral illness or immune system disorders, excluding Human Immunodeficiency Virus (HIV)?	☐	☐

Height: **Weight:**

Complete details for all questions answered "YES"

Question Number	Indicate Illness or Nature of Complaint/Treatment or Medication	Duration of Symptoms Treatment, Condition From: To:	Degree of Recovery	Names & Complete addresses of Physicians, Hospitals and Clinics

A copy of this application will be attached to and become part of the certificate.

AUTHORIZATION TO OBTAIN AND RELEASE INFORMATION

I AUTHORIZE Sentry Life Insurance Company of New York, 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 two years from the date below. A copy or fax of this Authorization is as valid as the original.

Employee Signature: _____ **Date:** _____

PRINT NAME _____

PLEASE INITIAL AND DATE ANY CHANGED ANSWERS.