GROUP DENTAL INSURANCE
GROUP DISABILITY INCOME INSURANCE
EMPLOYEE APPLICATION

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:
☐ Initial Enrollment
☐ 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:

☐ 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			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 ☐ Late	

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, 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 that the insurance applied for will not be in force unless Sentry Life Insurance Company approves this application. **Any person who, knowingly and with intent to defraud any insurance company or other person, files an application for insurance 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 subjects such person to criminal and/or civil penalties.** **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 _____. Employee Signature: _____ Date: _____ PRINT EMPLOYEE NAME _____ EMPLOYER NAME _____

AUTHORIZATION TO OBTAIN AND 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: _____