# EMPLOYEE APPLICATION

SENTRY® LIFE INSURANCE COMPANY

## IMPORTANT NOTICE - KEEP FOR YOUR RECORDS

ANY PERSON WHO KNOWINGLY PRESENTS A FALSE OR FRAUDULENT CLAIM FOR PAYMENT OF A LOSS OR BENEFIT OR KNOWINGLY PRESENTS FALSE INFORMATION IN AN APPLICATION FOR INSURANCE IS GUILTY OF A CRIME AND MAY BE SUBJECT TO FINES AND CONFINEMENT IN PRISON.

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.

If we notify you that coverage is not being issued or is not being issued as applied for, you have a right to receive further information regarding the decision process. To obtain such information you must send us a written request within 90 business days after we send you the notice of our decision. Within 21 business days after we receive your request, we will send you the reason(s) for the decision. We will also provide information supporting our decision and the name and address of any person or organization who supplied us with this information.

Medical information will be disclosed only to your attending physician. For disclosure of medical information, please include your physician's name and address with your request.

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)

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:<br>☐ Add Spouse* ☐ Add Dependent Child* ☐ Name Change*<br>☐ Other: _____<br>*Provide information in the section below titled "List all eligible Dependents."<br>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<br>☐ 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<br>$_____ |

**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 |
|---|---|---|---|
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| Sentry's Use Only | Base Life<br>Class<br>Amt. $<br>Deps. Life ☐ Y ☐ N | Opt. Life<br>Class<br>Amt. $ | STD<br>Class<br>Amt. $ | LTD<br>Class<br>Amt. $ | Dental<br>Class<br>☐ sgl ☐ eco<br>☐ eso ☐ family | PID #<br>Effective Date<br>Initial Date |
|---|---|---|---|---|---|---|
| | ☐ Non-Med<br>☐ Med | ☐ Non-Med<br>☐ Med | ☐ Non-Med<br>☐ Med | ☐ Non-Med<br>☐ Med | ☐ Non-Med<br>☐ 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, 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. 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. | ☐ | ☐ |
| 4) | Have you, during the last five years, undergone any surgical operation or been confined or treated in any hospital, sanitarium or similar institution? | ☐ | ☐ |
| 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? | ☐ | ☐ |
| 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)? | ☐ | ☐ |

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 |
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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 two years from the date below. A copy or fax of this Authorization is as valid as the original.

**Employee Signature:** _____ **Date:** _____

PRINT EMPLOYEE NAME: _____ EMPLOYER NAME: _____