Your Guide to Completing an

Sentinel Security Life

Application for Medicare Supplement Coverage

Overview

Plan Information (to be completed by Producer)

Section:

1. Applicant Information
2. Tobacco Use & Medicare Part A & B Information
3. Coverage eligibility
4. Health Questions & Current Medications

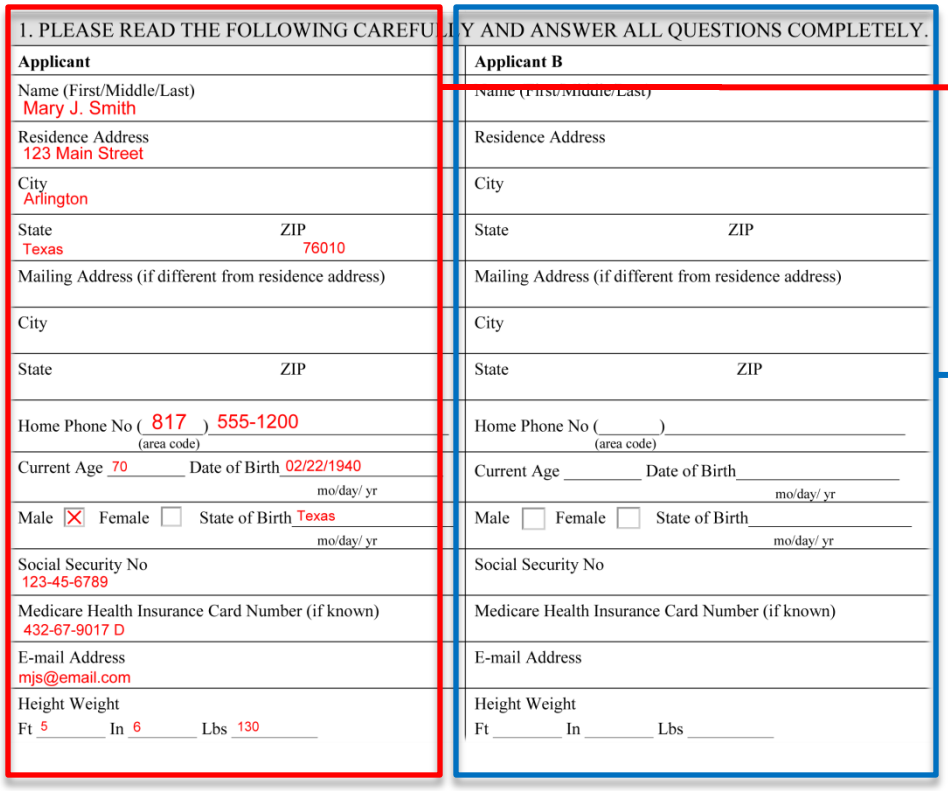
   (Skip this section if you are applying during an Open Enrollment or a Guaranteed Issue period.)
5. Billing & Payment Information
6. Applicant & Agent Declaration
7. Agent Certification to be completed by Applicant & Agent
8. Authorization to release medical Information to be completed by Applicant
9. Replacement Form: To be used only if the Proposed Insured is replacing another Medicare supplement or Medicare Advantage plan

Applicant Information

(to be completed by Producer)

Sentinel Security Life

Read the following carefully and answer **ALL** questions completely.



1. PLEASE READ THE FOLLOWING CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY.

Applicant	Applicant B
Name (First/Middle/Last): Mary J. Smith	Name (First/Middle/Last)
Residence Address: 123 Main Street	Residence Address
City: Arlington	City
State: Texas ZIP: 76010	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone No (817) 555-1200 (area code)	Home Phone No (_____) (area code)
Current Age 70 Date of Birth 02/22/1940 mo/day/ yr	Current Age _____ Date of Birth _____ mo/day/ yr
Male ☒ Female ☐ State of Birth Texas mo/day/ yr	Male ☐ Female ☐ State of Birth _____ mo/day/ yr
Social Security No: 123-45-6789	Social Security No
Medicare Health Insurance Card Number (if known): 432-67-9017 D	Medicare Health Insurance Card Number (if known)
E-mail Address: mjs@email.com	E-mail Address
Height Weight: Ft 5 In 6 Lbs 130	Height Weight: Ft _____ In _____ Lbs _____

For all sections: ALWAYS complete the "Applicant" (Red Box) Section

For all sections: 0NLY complete the "Applicant B" (Blue box) Section if to be Insured

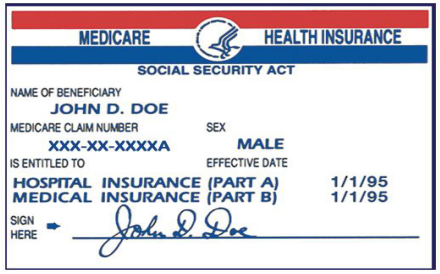
Reminder

- ❖Print Legibly in ink
- ❖Any corrections must be initialed by the owner, Proposed insured and the producer. Do not use any correction fluid or tape.

Tobacco Use & Medicare Part A & B Information

Sentinel Security Life

Section 2: Use the Client's Red, White & Blue Medicare card to complete this section for the Part A & B effective dates:



MEDICARE HEALTH INSURANCE

SOCIAL SECURITY ACT

NAME OF BENEFICIARY
JOHN D. DOE

MEDICARE CLAIM NUMBER
XXX-XX-XXXXA

SEX
MALE

IS ENTITLED TO

EFFECTIVE DATE

HOSPITAL INSURANCE (PART A) 1/1/95
MEDICAL INSURANCE (PART B) 1/1/95

SIGN HERE John D. Doe

Section 3: Coverage eligibility and Medicare Supplement/Select & Medicare Advantage replacement questions.

Question D: When question 2B is answered "yes", a copy of the Replacement Form is always left with the Applicant and the Original Replacement Form must be sent to the Home Office .

2. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

	Applicant	Applicant B
1. Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the **Outline of Coverage**?	Yes [X] No [ ]	Yes [ ] No [ ]
2. Have you used tobacco in any form in the past 12 months?	Yes [ ] No [X]	Yes [ ] No [ ]
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A?	Yes [X] No [ ]	Yes [ ] No [ ]
If "YES," what is your Part A effective date? 02/01/2005 (Applicant) / (Applicant B)		
If "NO," what is your eligibility date? (Applicant) / (Applicant B)		
2. Are you covered under Medicare Part B?	Yes [X] No [ ]	Yes [ ] No [ ]
If "YES," what is your Part B effective date? 08/01/2005 (Applicant) / (Applicant B)		
If "NO," indicate date you plan to enroll. (Applicant) / (Applicant B)		
3. Did you turn age 65 in the last six months?	Yes [ ] No [X]	Yes [ ] No [ ]
4. Did you enroll in Medicare Part B in the last six months?	Yes [ ] No [X]	Yes [ ] No [ ]
If "YES," indicate your effective date. (Applicant) / (Applicant B)		

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.**

3. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

To the Best of Your Knowledge:	Applicant	Applicant B
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.)	Yes [ ] No [X]	Yes [ ] No [ ]
2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force?		
(a) If "YES," with what company, and what plan do you have?	Yes [X] No [ ]	Yes [ ] No [ ]

Applicant	**Applicant B**
Name of Company ABC Company	Name of Company
Policy/Certificate Number 135790-24	Policy/Certificate Number
Plan F	Plan
Issue Date 7 / 1 / 2009	Issue Date / /

(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy?	Yes [X] No [ ]	Yes [ ] No [ ]
(c) If "YES," indicate termination date. 05/03/2010 (Applicant) / (Applicant B)		
(d) **If "YES," have you received a copy of the replacement notice?**	Yes [X] No [ ]	Yes [ ] No [ ]
If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.		
3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START (Applicant) END / START (Applicant B) END		
(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?	Yes [ ] No [ ]	Yes [ ] No [ ]
(b) **If "YES," have you received a copy of the replacement notice?**	Yes [ ] No [ ]	Yes [ ] No [ ]
(c) Reason for termination/disenrollment? (Applicant) / (Applicant B)		
(d) Planned date of termination/disenrollment? (Applicant) / (Applicant B)		

FOR AGENT USE ONLY

Replacement Information

Sentinel Security Life

Section 3 Continued: Additional information is required if the proposed insured is replacing existing health coverage.

	Applicant	Applicant B
(e) Was this your first time in this type of Medicare plan?	Yes ☐ No ☐	Yes ☐ No ☐
(f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan?	Yes ☐ No ☐	Yes ☐ No ☐
(g) Is your former Medicare supplement or Medicare select policy/certificate still available?	Yes ☐ No ☐	Yes ☐ No ☐
4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.)	Yes ☐ No ☒	Yes ☐ No ☐

(a) If "YES," with what company and what kind of policy/certificate? (List below.)

Applicant		Applicant B	
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate

(b) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank.
START_____ END_____ / START_____ END_____
Applicant Applicant B

(c) Reason for termination/disenrollment?_____ / _____
Applicant Applicant B

(d) Planned date of termination/disenrollment?_____ / _____
Applicant Applicant B

5. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.)	Yes ☐ No ☒	Yes ☐ No ☐
If "YES,"		
(a) Will Medicaid pay your premiums for this Medicare supplement policy?	Yes ☐ No ☒	Yes ☐ No ☐
(b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?	Yes ☐ No ☒	Yes ☐ No ☐
6. Producers shall list any other health insurance policies/certificates they have sold to the applicant.		

(a) List policies/certificates sold which are still in force.

Applicant	Applicant B
Name of Company ABC Company	Name of Company
Policy/Certificate Number 135790-4	Policy/Certificate Number
Description of Benefits Plan F	Description of Benefits
Effective Date of Coverage 07/01/2009	Effective Date of Coverage

(b) List policies/certificates sold in the past five (5) years which are no longer in force.

Applicant	Applicant B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Description of Benefits	Description of Benefits
Effective Date of Coverage	Effective Date of Coverage

Health Questions and Current Medications

(Skip this section if you are applying during Open Enrollment or a Guaranteed Issue period.)

Sentinel Security Life

- Each change must be reviewed and initialed. Initials will be required by the proposed insured, owner and producer.

OR

- A new page 4 must be completed and signed to replace the original page 4

- Producer must confirm in the Producer Report that a new page 4 was completed

If you are applying during Open Enrollment or a Guaranteed Issue period, SKIP SECTION 4 and GO TO SECTION 5.

4. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. Make sure all questions are answered by each applicant. If either you or Applicant B answer "YES" to any of the following questions 1-14, that person is not eligible for coverage.

	Applicant	Applicant B
1. Are you currently hospitalized, confined to a nursing facility, receiving hospice or home health care; or, are you bedridden or confined to a wheelchair?	Yes ☐ No ☒	Yes ☐ No ☐
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	Yes ☐ No ☒	Yes ☐ No ☐
3. Have you been diagnosed with Parkinson's Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis?	Yes ☐ No ☒	Yes ☐ No ☐
4. Have you been diagnosed with Alzheimer's Disease, Senile Dementia, or any other cognitive disorder?	Yes ☐ No ☒	Yes ☐ No ☐
5. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)?	Yes ☐ No ☒	Yes ☐ No ☐
6. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? If you do not have diabetes, this question should be answered "NO".	Yes ☐ No ☒	Yes ☐ No ☐
7. Do you have diabetes that has ever required more than 50 units of insulin daily?	Yes ☐ No ☒	Yes ☐ No ☐
8. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?	Yes ☐ No ☒	Yes ☐ No ☐
9. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?	Yes ☐ No ☒	Yes ☐ No ☐
10. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	Yes ☐ No ☒	Yes ☐ No ☐
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	Yes ☐ No ☒	Yes ☐ No ☐
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes ☐ No ☒	Yes ☐ No ☐
13. Have you been hospital confined three or more times in the last two years?	Yes ☐ No ☒	Yes ☐ No ☐
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes ☐ No ☒	Yes ☐ No ☐
15. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If "YES," please list the drug and the condition in the following table.	Yes ☒ No ☐	Yes ☐ No ☐

Applicant (please attach a separate sheet if needed)		**Applicant B** (please attach a separate sheet if needed)
Lotrel	Medication Name (copy off pharmacy label)	
5 years ago	Date **Originally** Prescribed	
10/40 daily	Frequency and Dosage	
Blood Pressure	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

FOR AGENT USE ONLY

Billing & Payment Information

Sentinel Security Life

Specify Checking or Savings for your EFT payment and the requested draft date.

Please be sure to complete your Financial Institution's information and include a voided check.

5. BILLING INFORMATION

I would like my monthly direct payment to come from my (check one) on the 15 **day of the month:**
☒ Checking **Please attach a voided check** ☐ Savings **Please ask your financial institution to verify that this EFT will be accepted and that the information below is correct.**

Financial Institution Name: XYZ Bank	Phone #: (800) 123-5555
Financial Institution Address: 123 Center Street	
Transit Routing #: 123456	Account #: 0123456789

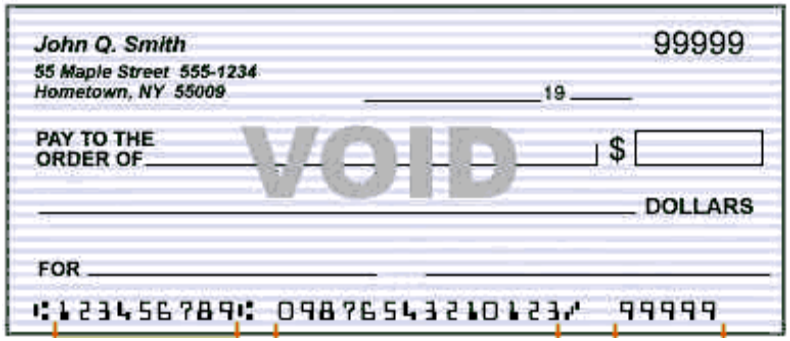
I hereby request and authorize Sentinel Security Life to initiate a charge to my account at the named Financial Institution to pay the premium(s) due, after the first premium has been paid, on any policy issued in connection with this application. The term "charge" shall include items initiated by electronic means, checks, drafts or any other order. I have the right to stop payment of a charge by giving notice to Sentinel Security Life or the Financial Institution in such time as to afford a reasonable opportunity to act prior to charging my account. I agree that Sentinel Security Life's rights in respect to each charge shall be the same as if it were a check made payable to Sentinel Security Life and personally signed by me. If any charge is dishonored for any reason, Sentinel Security Life shall not be under any liability even though such dishonor results in the forfeiture of insurance.

Mary J Smith
Signature as it appears on financial institution records

MARY J SMITH
Print name of account owner (if other than proposed insured)

05/14/2010
Date

Please be sure to include the applicant's VOIDED check with the application.



Authorization & Acknowledgment

Sentinel Security Life

The Applicant must always read this page and sign below.

The Applicant's signature at the bottom of the page certifies they have read and understand the information on this page and represents the answers are true.

Always provide your producer number to insure commissions are paid properly.

6. PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need more than one type of coverage in addition to your Medicare benefits.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I wish to apply for a Medicare supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, (a) upon acceptance of the completed application, each applicant will receive a separate policy; (b) my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Sentinel Security Life Insurance Company.
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 may be guilty of a crime and may be subject to civil fines and criminal penalties.
I understand the Company may obtain an investigative consumer report on me and a telephone interview may be necessary to verify or supplement information given to the Company on this application. I understand my right to request to be interviewed and that I may request a copy of the report if no personal interview is conducted. A photocopy of this form will be as valid as the original; this Authorization and Acknowledgment will be valid for 24 months after it is signed.

Dated at Arlington (City) Texas (State), on 5 (Month) 14 (Day), 2010 (Year) Mary J Smith (Applicant's Signature)

Dated at _____ (City) _____ (State), on _____ (Month) _____ (Day), _____ (Year) _____ (Applicant B's Signature (if applying))

Premium Must Accompany Application
I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

Joe Agent
(Signature of Licensed Producer) | (Signature of Licensed Producer)

M000009876
PRODUCER NUMBER / (STAMP) | PRODUCER NUMBER / (STAMP)

FOR AGENT USE ONLY

Additional Prescription Information

Use this section to provide additional information and comments.

ADDITIONAL INFORMATION: PART 4 - CON'T. HEALTH /MEDICAL QUESTIONS - Question #15		
Applicant (please attach a separate sheet if needed)		**Applicant B** (please attach a separate sheet if needed)
20 Corgard	Medication Name (copy off pharmacy label)	
4 years ago	Date **Originally** Prescribed	
25 ml daily	Frequency and Dosage	
Cholesterol	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date **Originally** Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

SECTION FOR ADDITIONAL COMMENTS	
Applicant (please attach a separate sheet if needed)	**Applicant B** (please attach a separate sheet if needed)

FOR AGENT USE ONLY

Definitions of Eligible Person for Guaranteed Issue and Creditable Coverage

Sentinel Security Life

It is mandatory in some states that the Applicant read all the information on this page.

Definitions of Eligible Person for Guaranteed Issue and Creditable Coverage

Eligible Persons. An eligible person is an individual described in any of the following paragraphs:

(1) The individual is enrolled under an employee welfare benefit plan that provides health benefits that supplement the benefits under Medicare, and the plan terminates, or the plan ceases to provide all such supplemental health benefits to the individual; or the individual is enrolled under an employee welfare benefit plan that is primary to Medicare and the plan terminates or the plan ceases to provide all health benefits to the individual because the individual leaves the plan.

(2) The individual is enrolled with a Medicare Advantage organization under a Medicare Advantage plan under Part C of Medicare, and any of the following circumstances apply, or the individual is 65 years of age or older and is enrolled with a program of All-Inclusive Care for the Elderly (PACE) provider under section 1894 of the Social Security Act, and there are circumstances similar to the following that would permit discontinuance of the individual's enrollment with such provider if such individual were enrolled in a Medicare Advantage plan:

(a) The certification of the organization or plan has been terminated; or

(b) The organization has terminated or otherwise discontinued providing the plan in the area in which the individual resides;

(c) The individual is no longer eligible to elect the plan because of a change in the individual's place of residence or other change in circumstances specified by the Secretary, but not including termination of the individual's enrollment on the basis described in section 1851 (g)(3)(B) of the Social Security Act (where the behavior as specified in standards under section 1856), or the plan is terminated for all individuals within a residence area;

(d) The individual demonstrates, in accordance with guidelines established by the Secretary, that:

1. The organization offering the plan substantially violated a material provision of the organization's contract under U.S.C Title 42, Chapter 7, Subchapter XVIII, Part D in relation to the individual, including the failure to provide an individual on a timely basis medically necessary care for which benefits are available under the plan or the failure to provide such covered case in accordance with applicable quality standards; or
2. The organization, or agent or other entity acting on the organization's behalf, materially misrepresented the plan's provisions in marketing the plan to the individual; or

(e) The individual meets such other exceptional conditions as the Secretary may provide.

(3) The individual is enrolled with an entity listed in subparagraphs (A) – (D) of this paragraph and enrollment ceases under the same circumstances that would permit discontinuance of an individual's election of coverage under paragraph (2) of this subsection:

a. An eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost)'
b. A similar organization operating under a contract under demonstration project authority, effective for periods before April 1, 1999;
c. An organization under an agreement under section 1833(a)(1)(A) of the Social Security Act (health care prepayment plan); or
d. An organization under a Medicare Select policy; and

(4) The individual is enrolled under a Medicare supplement policy and the enrollment ceases because:

a. Of the insolvency of the issuer or bankruptcy of the nonissuer organization; or of involuntary termination of coverage or enrollment under the policy;
b. The issuer of the policy is substantially violated a material provision of the policy; or
c. The issuer, or an agent or other entity acting on the issuer's behalf, materially misrepresented the policy's provisions in marketing the policy to the individual;

(5) The individual was enrolled under a Medicare supplement policy and terminates enrollment and subsequently enrolls, for the first time, with any Medicare Advantage organization under a Medicare Advantage plan under part C of Medicare, any eligible organization under a contract under section 1876 of the Social Security Act (Medicare cost), any similar organization operating under demonstration project authority, any PACE provider under section 1894 of the Social Security Act, or a Medicare Select policy; and the subsequent enrollment is terminated by the individual during any period within the first 12 months of such subsequent enrollment (during which the individual is permitted to terminate such subsequent enrollment under section 1851(e) of the Social Security Act); or

(6) The individual, upon first becoming enrolled in Medicare part B for benefits at age 65 or older, enrolls in a Medicare Advantage plan under part C of Medicare, or with a PACE provider under section 1894 of the Social Security Act, and disenrolls from the plan or program no later than 12 months after the effective date of enrollment.

(7) The Individual enrolls in a Medicare Part D plan during the initial enrollment period and, at the time of enrollment in Part D, was enrolled under a Medicare supplement policy that cover outpatient prescription drugs and the individual terminates enrollment in the Medicare supplement policy and submits evidence of enrollment in Medicare Part D with the application for a policy described in subsection (c)(4) of this section.

(8) The individual loses eligibility for health benefits under Medicaid.

Creditable Coverage means (a) a self-funded or self-insured employee welfare benefit plan that provides health benefits and that is established in accordance with the Employee Retirement Income Security Act of 1974 (29 U.S.C. Section 1001 et seq.); (b) a group health benefit plan provided by a health insurance carrier or an HMO; (c) an individual health insurance certificate or evidence of coverage; (d) Part A or Part B of Title XVIII of the Social Security Act; (e) Title XIX of the Social Security Act, other than coverage consisting solely of benefits under section 1928; (f) Chapter 55 of Title 10 (CHAMPUS); (g) a medical care program of the Indian Health Service or of a tribal organization; (h) a state or political subdivision health benefits risk pool; (i) a health plan offered under Chapter 89 of Title 5 (Federal Employees Health Benefits Program); (j) a public health plan (as defined in federal regulation); (k) a health benefit plan under section 5(e) of the Peace Corps Act (22 United States Code 2504(e)); or (l) short-term limited duration insurance.

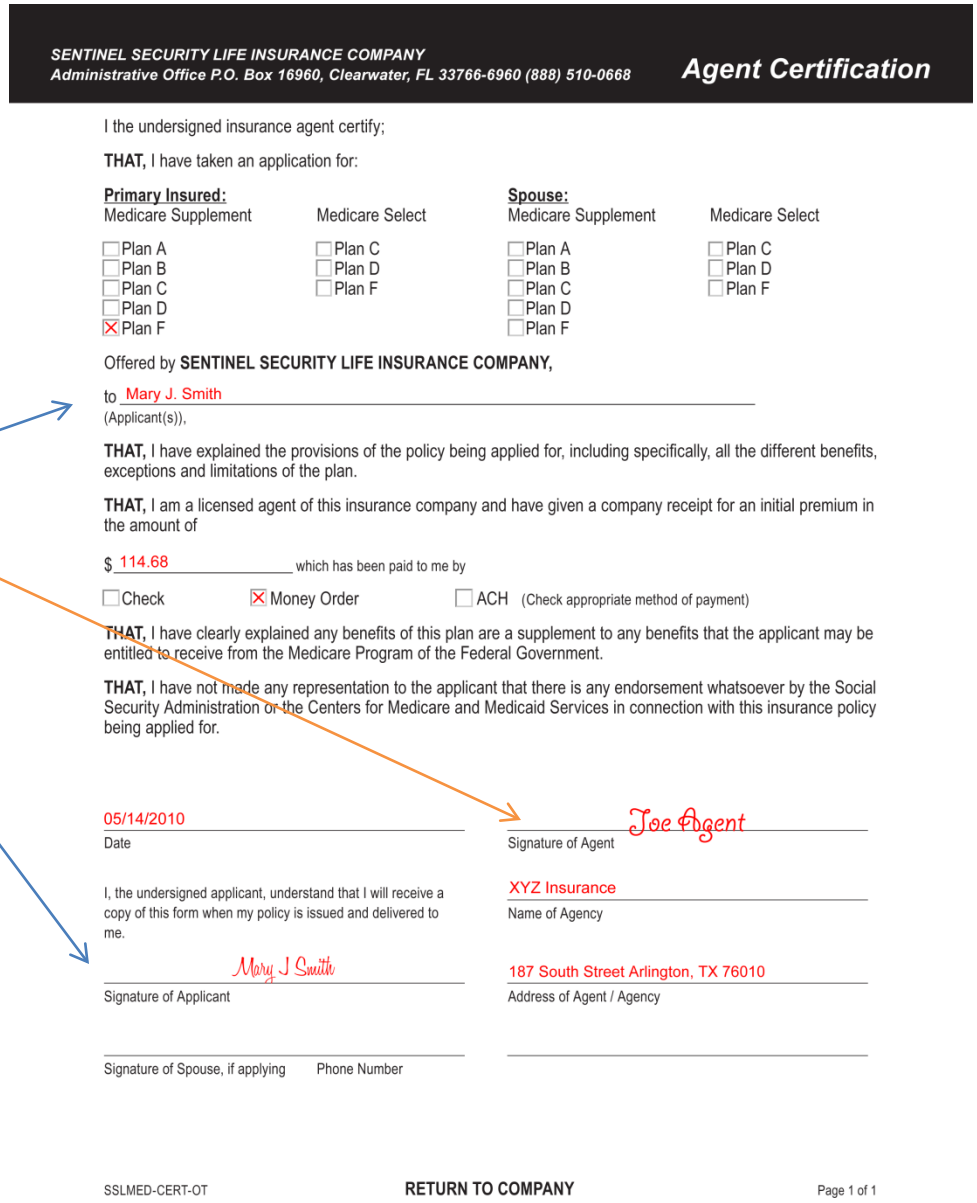
FOR AGENT USE ONLY

Agent Certification

The agent certification page must be completed by the agent and signed by both the agent and applicant.

Agent's Signature

Applicant's Signature



SENTINEL SECURITY LIFE INSURANCE COMPANY
Administrative Office P.O. Box 16960, Clearwater, FL 33766-6960 (888) 510-0668

Agent Certification

I the undersigned insurance agent certify;

THAT, I have taken an application for:

Primary Insured: Medicare Supplement		Medicare Select		**Spouse:** Medicare Supplement		Medicare Select	
☐ Plan A		☐ Plan C		☐ Plan A		☐ Plan C	
☐ Plan B		☐ Plan D		☐ Plan B		☐ Plan D	
☐ Plan C		☐ Plan F		☐ Plan C		☐ Plan F	
☐ Plan D				☐ Plan D			
☒ Plan F				☐ Plan F			

Offered by **SENTINEL SECURITY LIFE INSURANCE COMPANY,**

to Mary J. Smith
(Applicant(s)),

THAT, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of

$ 114.68 which has been paid to me by

☐ Check ☒ Money Order ☐ ACH (Check appropriate method of payment)

THAT, I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services in connection with this insurance policy being applied for.

05/14/2010
Date

Joe Agent
Signature of Agent

I, the undersigned applicant, understand that I will receive a copy of this form when my policy is issued and delivered to me.

XYZ Insurance
Name of Agency

Mary J Smith
Signature of Applicant

187 South Street Arlington, TX 76010
Address of Agent / Agency

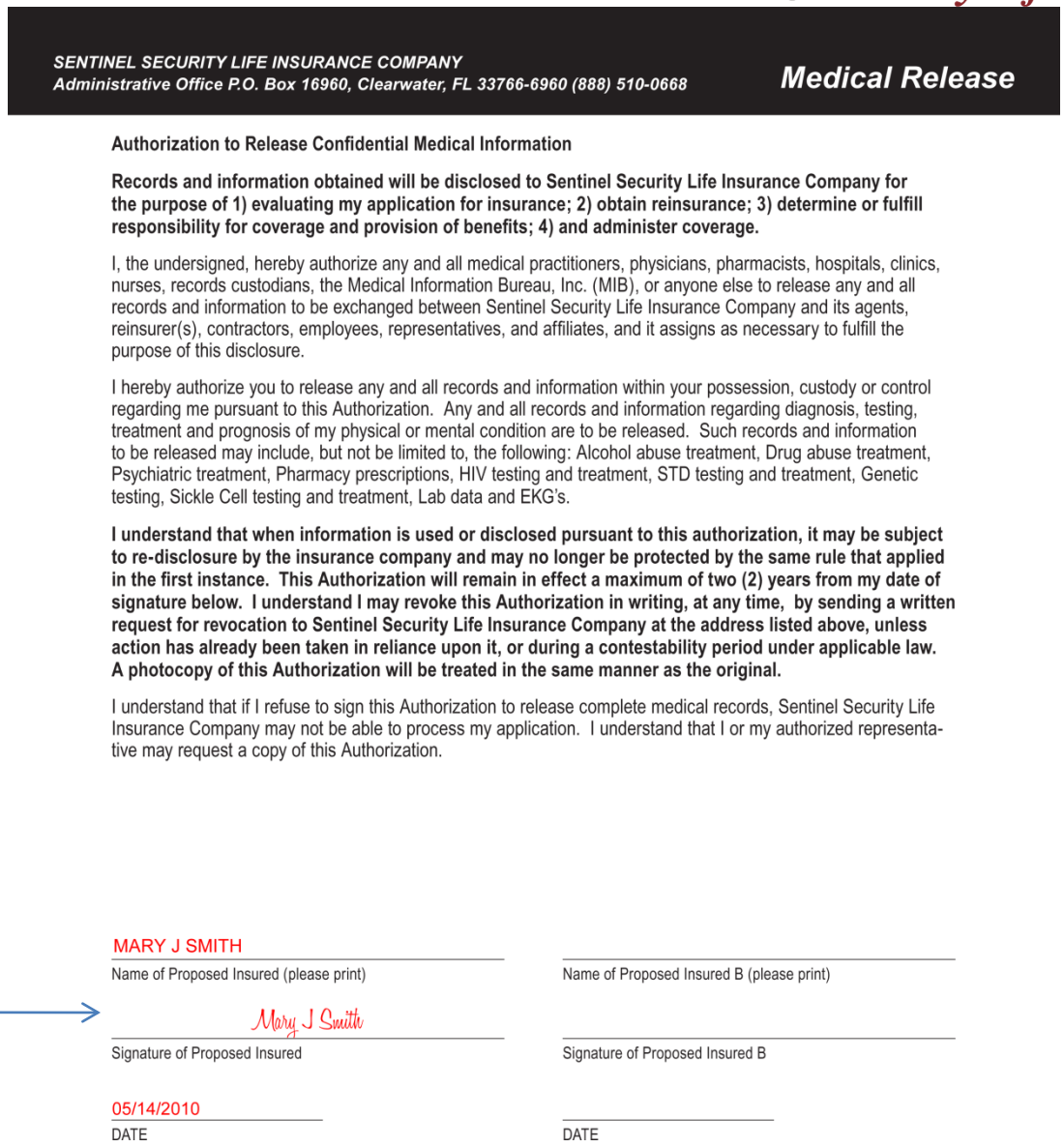
Signature of Spouse, if applying Phone Number

SSLMED-CERT-OT **RETURN TO COMPANY** Page 1 of 1

FOR AGENT USE ONLY

Medical Release

The Authorization to Release Confidential Medical Information must be completed by the proposed insured before Sentinel Security Life Insurance Company can process the application.



SENTINEL SECURITY LIFE INSURANCE COMPANY
Administrative Office P.O. Box 16960, Clearwater, FL 33766-6960 (888) 510-0668

Medical Release

Authorization to Release Confidential Medical Information

Records and information obtained will be disclosed to Sentinel Security Life Insurance Company for the purpose of 1) evaluating my application for insurance; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) and administer coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, the Medical Information Bureau, Inc. (MIB), or anyone else to release any and all records and information to be exchanged between Sentinel Security Life Insurance Company and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and it assigns as necessary to fulfill the purpose of this disclosure.

I hereby authorize you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, the following: Alcohol abuse treatment, Drug abuse treatment, Psychiatric treatment, Pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, Genetic testing, Sickle Cell testing and treatment, Lab data and EKG's.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Sentinel Security Life Insurance Company at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Sentinel Security Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

MARY J SMITH
Name of Proposed Insured (please print)

Name of Proposed Insured B (please print)

Mary J Smith
Signature of Proposed Insured

Signature of Proposed Insured B

05/14/2010
DATE

DATE

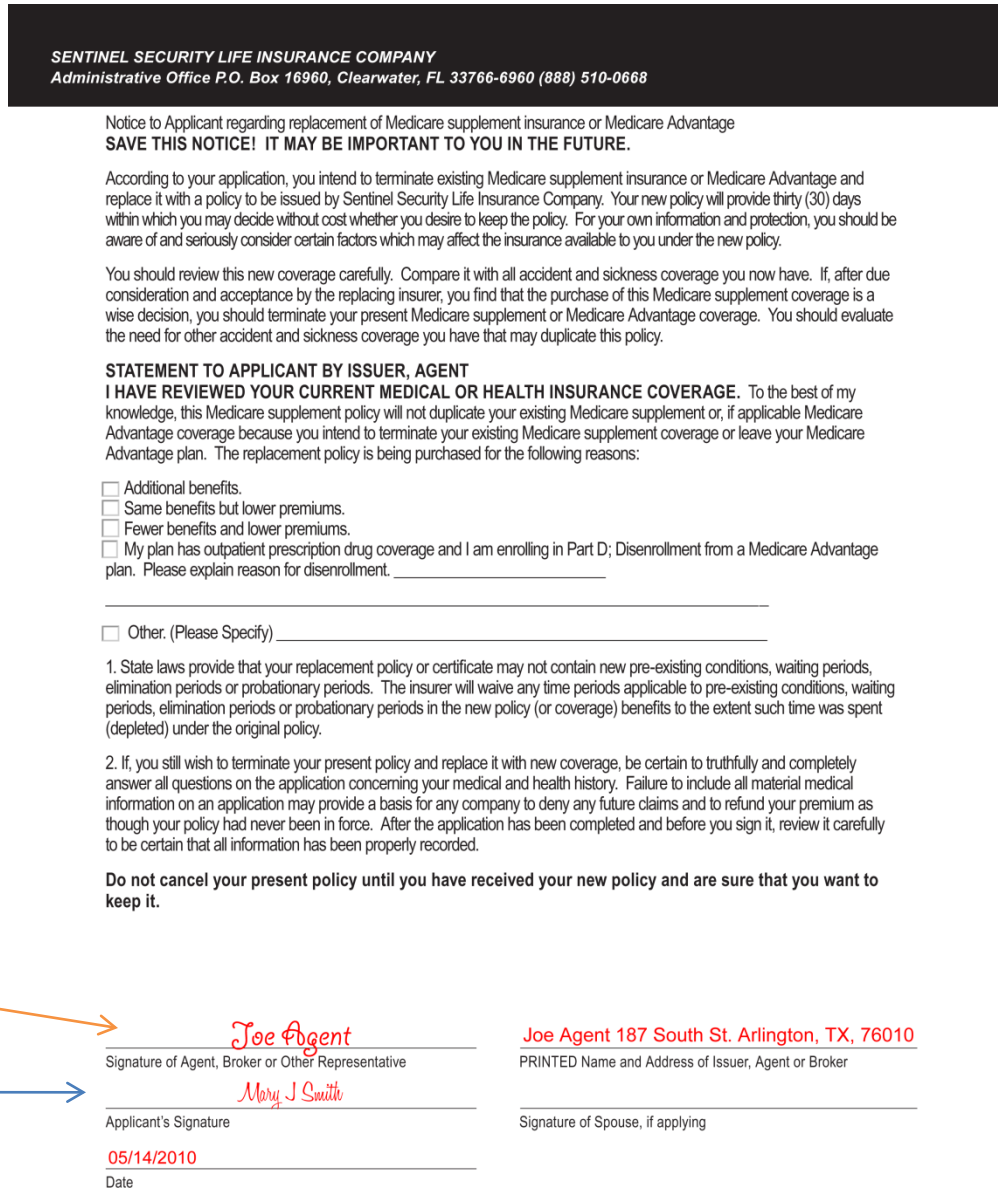
Applicant signature required →

FOR AGENT USE ONLY

Replacement Form

Sentinel Security Life

The Applicant completes the Replacement Form only when they are canceling a Medicare Supplement or a Medicare Advantage Plan. The Original is sent to Home Office and the Applicant must receive a copy.



SENTINEL SECURITY LIFE INSURANCE COMPANY
Administrative Office P.O. Box 16960, Clearwater, FL 33766-6960 (888) 510-0668

Notice to Applicant regarding replacement of Medicare supplement insurance or Medicare Advantage
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement insurance or Medicare Advantage and replace it with a policy to be issued by Sentinel Security Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance available to you under the new policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration and acceptance by the replacing insurer, you find that the purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT
I HAVE REVIEWED YOUR CURRENT MEDICAL OR HEALTH INSURANCE COVERAGE. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reasons:

- ☐ Additional benefits.
- ☐ Same benefits but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D; Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment. _____

_____

- ☐ Other. (Please Specify) _____

1. State laws provide that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) benefits to the extent such time was spent (depleted) under the original policy.

2. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for any company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Agent Signature

Applicant Signature

Joe Agent
Signature of Agent, Broker or Other Representative

Joe Agent 187 South St. Arlington, TX, 76010
PRINTED Name and Address of Issuer, Agent or Broker

Mary J Smith
Applicant's Signature

Signature of Spouse, if applying

05/14/2010
Date

FOR AGENT USE ONLY

Sentinel Life Agent Support

Application Submission

Medicare Supp and/or Combo Application – submit new business to:

Mail: Sentinel Security Life
P.O. Box 16960
Clearwater, FL 33766 – 6960

Fax: 1-800-719-1264 (only if initial premium paid by ACH)

Phone: 1-888-510-0668

Stand-alone Final Expense Application – submit new business to:

Mail: Sentinel Security Life, Attn: New Business
P.O. Box 65478
Salt Lake City, UT 84165

Express Mail: Sentinel Security Life, Attn: New Business
2121 South State Street
Salt Lake City, UT 84115

Fax: 1-877-841-8613

Phone: 1-800-247-1423

www.sentinellife.org