

Thank you for your interest in applying for the Sentinel Life Medicare Supplement plan!

This application needs to be reviewed and signed by an Agent before it can be submitted to Sentinel Life. You may email, fax or mail it in to CDA Insurance:

- Fax: 1.541.284.2994
- Email: dann@lowinsure.com
- Mail: CDA Insurance LLC
2160 W 11th Ave
Eugene, Oregon 97402

Other Important Information
Download Medicare's Choosing a Medigap Policy Guide (.pdf)
Download Policy Outline (.pdf)

If you should have any questions on the application, please call us at 1.800.884.2343 or 1.541.434.9613.

Producer checklist for completing the Medicare Supplement application

This packet contains the following forms needed to complete a Medicare Supplement application. Please tear out the application and all pages marked "RETURN TO COMPANY" and leave the remaining pages with the applicant(s). Please review the following information carefully and complete all needed forms:

- Application for Medicare Supplement/Select (Form SSLMED10-WA)
 - If the applicant(s) is applying during Open Enrollment or a Guaranteed Issue period Section 4 is not required to be completed
 - Section 5 should only be completed if the applicant(s) would like his/her payments to be deducted automatically from their checking/savings account. This option only applies if premiums are paid monthly.
- Producer Certification (Form SSLMED-CERT-WA) - This form must be signed by the producer and by the applicant(s)
- Calculate Your Premium – This form is used in coordination with the Outline of Coverage to calculate the correct premium. This form must be returned with the application
- Fax Transmittal – Follow the instructions on this form only if the applicant(s) elects to pay premiums using ACH and you would like to fax the underwriting documents instead of mailing them
- Authorization to Release Confidential Medical Information (Form SSLHIPAA2-WA) – Must be completed only if applying outside Open Enrollment or a Guaranteed Issue period. If a husband and wife are both applying for coverage on the same application then both must sign the form
- Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage (Form SSLMED-REP-WA) - This form must be completed if any replacement is involved. One signed copy must be returned to the Administrative Office and the other signed copy must be left with the applicant(s)
- Medicare Supplement/Select Initial Premium Receipt (Form SSLMED-100-WA) – This form must be left with the applicant(s) and the full modal premium is required with all applications

Please note, you are also required to provide the applicant(s) with the following items:

- Guide to Health Insurance for People with Medicare
- Outline of Coverage (Form SSLMED-OTLN10-WA)

Premiums and Policy Fee

Utilize the Outline of Coverage to determine premiums:

- Determine ZIP code where the client resides and find the correct rate page for that ZIP code
- Determine Plan
- Determine if non-tobacco or tobacco
- Find Age/Gender - Verify that the age and date of birth are the exact age as of the application date, his will be your base monthly premium
- Use the Calculate Your Premium form to adjust the monthly premium for different modes and to add the policy fee

There will be a one-time application fee of \$25.00 that must be collected with each applicant's initial payment. For a husband and wife written on the same application, \$50 in fees must be collected. This will not affect the renewal premiums and the **application fee doesn't apply in WA.**

Mailing Address

Sentinel Security Life Insurance Company
P.O. Box 16960
Clearwater, FL 33766-6960

Overnight/Express Address

Sentinel Security Life Insurance Company
2536 Countryside Boulevard, Suite 501
Clearwater, FL 33763

FAX Number for New Business - ACH Applications

1-800-719-1264

Sentinel Security Life Insurance Company

Administrative Office

P.O. Box 16960

Clearwater, FL 33766-6960

Application For Medicare Supplement Coverage

PLAN INFORMATION (to be completed by **Producer**)

NOTE: For ALL sections, ONLY complete the Applicant B information if to be insured.

<u>APPLICANT</u>		<u>APPLICANT B</u>	
Medicare Supplement Plan		Medicare Supplement Plan	
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F		<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F	
Requested Effective Date		Requested Effective Date	
Mail Policy To: <input type="checkbox"/> Insured <input type="checkbox"/> Producer		Mail Policy To: <input type="checkbox"/> Insured <input type="checkbox"/> Producer	
Premium Collected \$		Premium Collected \$	
Renewal \$		Renewal \$	
Renewal Mode A, S, Q, ACH (direct monthly not available)		Renewal Mode A, S, Q, ACH (direct monthly not available)	

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

Applicant	Applicant B
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address
City	City
State ZIP	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 (_____) _____ <small>(area code)</small>	Home Phone No (_____) _____ <small>(area code)</small>
Current Age _____ Date of Birth _____ <small>mo/day/ yr</small>	Current Age _____ Date of Birth _____ <small>mo/day/ yr</small>
Male <input type="checkbox"/> Female <input type="checkbox"/> State of Birth _____	Male <input type="checkbox"/> Female <input type="checkbox"/> State of Birth _____
Social Security No	Social Security No
Medicare Health Insurance Card Number (if known)	Medicare Health Insurance Card Number (if known)
E-mail Address	E-mail Address
Height Weight Ft _____ In _____ Lbs _____	Height Weight Ft _____ In _____ Lbs _____

2. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.

1. Have you received a copy of the Guide to Health Insurance for People with Medicare and the Outline of Coverage ?	Applicant Yes <input type="checkbox"/> No <input type="checkbox"/>	Applicant B Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you used tobacco in any form in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A? If "YES," what is your Part A effective date? _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "NO," what is your eligibility date? _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Are you covered under Medicare Part B? If "YES," what is your Part B effective date? _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "NO," indicate date you plan to enroll. _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Did you turn age 65 in the last six months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Did you enroll in Medicare Part B in the last six months? If "YES," indicate your effective date. _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

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 Yes <input type="checkbox"/> No <input type="checkbox"/>	Applicant B Yes <input type="checkbox"/> No <input type="checkbox"/>
1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.)		
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant	Applicant B
Name of Company	Name of Company
Policy/Certificate Number	Policy/Certificate Number
Plan	Plan
Issue Date / /	Issue Date / /

(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy? (c) If "YES," indicate termination date. _____ / _____ Applicant Applicant B	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(d) If "YES," have you received a copy of the replacement notice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 _____ END _____ / START _____ END _____ Applicant Applicant B		
(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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(b) If "YES," have you received a copy of the replacement notice?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
(c) Reason for termination/disenrollment? _____ / _____ Applicant Applicant B		
(d) Planned date of termination/disenrollment? _____ / _____ Applicant Applicant B		

(e) Was this your first time in this type of Medicare plan? (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? (g) Is your former Medicare supplement or Medicare select policy/certificate still available? 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.) (a) If "YES," with what company and what kind of policy/certificate? (List below.)		Applicant Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Applicant B Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
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 _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Applicant Applicant B </div> (c) Reason for termination/disenrollment? _____ / _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Applicant Applicant B </div> (d) Planned date of termination/disenrollment? _____ / _____ <div style="display: flex; justify-content: space-around; width: 100%;"> Applicant Applicant B </div>			
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.) If "YES," (a) Will Medicaid pay your premiums for this Medicare supplement policy? (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium? 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.		Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
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	
(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	

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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Have you been diagnosed with Alzheimer’s Disease, Senile Dementia, or any other cognitive disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. Do you have diabetes that has ever required more than 50 units of insulin daily?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Have you been hospital confined three or more times in the last two years?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
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 <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant (please attach a separate sheet if needed)		Applicant B (please attach a separate sheet if needed)
	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	

5. BILLING INFORMATION

I would like my monthly direct payment to come from my (check one) on the _____ 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:

Phone #:

Financial Institution Address:

Transit Routing #:

Account #:

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.

Signature as it appears on financial institution records

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

Date

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 multiple coverage.
- 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 reinstated 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 reinstated 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 reinstated 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 reinstated 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. It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits. 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 _____, on _____, _____
 City State Month Day Year Applicant's Signature

Dated at _____, on _____, _____
 City State 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.

(Signature of Licensed Producer)

(Signature of Licensed Producer)

E000009695

PRODUCER NUMBER / (STAMP)

PRODUCER NUMBER / (STAMP)

I the undersigned insurance producer certify;

THAT, I have taken an application for:

Primary Insured:

Medicare Supplement Medicare Select

- | | |
|---------------------------------|---------------------------------|
| <input type="checkbox"/> Plan A | <input type="checkbox"/> Plan C |
| <input type="checkbox"/> Plan B | <input type="checkbox"/> Plan D |
| <input type="checkbox"/> Plan C | <input type="checkbox"/> Plan F |
| <input type="checkbox"/> Plan D | |
| <input type="checkbox"/> Plan F | |

Spouse:

Medicare Supplement Medicare Select

- | | |
|---------------------------------|---------------------------------|
| <input type="checkbox"/> Plan A | <input type="checkbox"/> Plan C |
| <input type="checkbox"/> Plan B | <input type="checkbox"/> Plan D |
| <input type="checkbox"/> Plan C | <input type="checkbox"/> Plan F |
| <input type="checkbox"/> Plan D | |
| <input type="checkbox"/> Plan F | |

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

to _____
(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 producer of this insurance company and have given a company receipt for an initial premium in the amount of

\$ _____ 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.

Date

Signature of Producer

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

CDA Insurance LLC
Name of Agency

Signature of Applicant

PO Box 26540, Eugene, OR 97402
Address of Producer / Agency

Signature of Spouse, if applying

800.884.2343
Phone Number

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 producers, reinsurer(s), contractors, employees, representatives, affiliates, and 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.

Name of Proposed Insured (please print)

Name of Proposed Insured B (please print)

Signature of Proposed Insured

Signature of Proposed Insured B

DATE

DATE

Medicare Supplement Plan _____

Before you begin: If you're not in your open enrollment or guarantee issue period, please go to page 2 to determine your eligibility for coverage.

Steps	Example Rate displayed is used for calculation purposes only.	Applicant's Premium	Applicant B's Premium
Premium Write in your Medicare supplement plan's premium from the Outline of Coverage table.	\$128.52		
Payment Options To determine other payment schedules, multiply your monthly premium by: 3 to pay four times a year (quarterly) 6 to pay twice a year (semi-annually) 12 to pay once a year (annually)	\$128.52 Monthly Payment \$385.56 Quarterly Payment \$771.12 Semi-Annual Payment \$1,542.24 Annual Payment		
Enrollment/Policy Fee There is a one-time application fee of \$25. This will be collected with your initial payment and will NOT affect your renewal premium. This fee is non-refundable.	NOT APPLICABLE IN WA. $\$128.52 + \$25.00 = \$153.52$ Example shows initial payment (monthly schedule).		

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.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, 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, PRODUCER
I HAVE REVIEWED YOUR CURRENT MEDICAL FOR 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 reason(s) (check one):

- Additional benefits.
- No change in 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) for similar 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.

Signature of Producer or other Representative

PRINTED Name and Address of Issuer or Producer

Applicant's Signature

Signature of Spouse, if applying

Date

SENTINEL SECURITY LIFE INSURANCE COMPANY

Administrative Office P.O. Box 16960, Clearwater, FL 33766-6960 (888) 510-0668

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You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, 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, PRODUCER
I HAVE REVIEWED YOUR CURRENT MEDICAL FOR 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 reason(s) (check one):

- Additional benefits.
- No change in 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) for similar 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.

Signature of Producer or other Representative

PRINTED Name and Address of Issuer or Producer

Applicant's Signature

Signature of Spouse, if applying

Date

INVESTIGATIVE CONSUMER REPORT NOTICE TO APPLICANT

Federal law requires that notice of investigation be given to persons applying for insurance. In making this application for insurance to Sentinel Security Life Insurance Company (the Company), it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living (the term "mode of living" does not relate directly or indirectly to the sexual orientation of any proposed insured). You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon proper identification, you have the right to inspect and/or receive a copy of the report from the consumer reporting agency. You have the right to make a written request to the Company within a reasonable period of time to receive additional detailed information about the nature and scope of the investigation. Write to: Underwriting Department, Sentinel Security Life Insurance Company, P.O. Box 16960, Clearwater, Florida, 33766-6960.

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Sentinel Security Life Insurance Company (the Company) or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, 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 member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company or its reinsurer(s) may also release information from 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. Information for consumers about MIB may be obtained on its website at www.mib.com.

MEDICARE SUPPLEMENT / SELECT INITIAL PREMIUM RECEIPT		
MAKE CHECK PAYABLE TO: SENTINEL SECURITY LIFE INSURANCE COMPANY		
Received from _____ (Proposed Insured) an application for a Medicare Supplement Policy with Sentinel Security Life Insurance Company (the Company), Salt Lake City, Utah and \$ _____ for the initial premium. In the event the application is not accepted by the Company, the above amount will be refunded. No obligation is incurred by the Company unless said application is approved by the Company at its Administrative Office and a policy is issued.		
<u>Dann Loewenthal</u> Producer's Name (please print)	_____ Producer's Signature	_____ Date