Sentinel Security Life

Lighting the way to financial security

Sentinel Security Life Insurance Company

Medicare Supplement Insurance

Standard Medicare
Supplement Insurance Plan
MARYLAND

SENTINEL SECURITY LIFE INSURANCE COMPANY
PO BOX 27248 SALT LAKE CITY, UTAH 84127-0248
STATE OF DOMICILE: UTAH

Agent 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** *(Form SSLMED10-MD)*
- If the applicant(s) is applying during Open Enrollment or a Guaranteed Issue period, Section 7 is not required to be completed.
- Section 6 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.

☐ **Authorization to Release Confidential Medical Information** *(Form SSLHIPAA3-OT)* – 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-OT)* - This form must be completed if any replacement is involved. One signed copy must be returned to the Home Office and the other signed copy must be left with the applicant(s).

☐ **Agent Certification** *(Form SSLMED-CERT-MD)* - This form must be signed by the agent 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.

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**

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, $50.00 in fees must be collected. This will not affect the renewal premiums.

Mailing Address
Sentinel Security Life Insurance Company
PO Box 27248
Salt Lake City, UT 84127-0248

Federal Express/UPS
Sentinel Security Life Insurance Company
1405 West 2200 South
Salt Lake City, UT 84119

Fax/Email
Attn: New Business - **ACH Applications 888-433-4795**
newbusiness@sslco.com

SENTINEL SECURITY LIFE INSURANCE COMPANY

P.O. Box 27248 Salt Lake City, Utah 84127-0248
Phone: 1-800-247-1423

Application For: ☐ **Medicare Supplement Coverage**

☐ **Medicare Supplement Conversion; Policy Number** _____

Agent Name(s) / Agent Number (s):

SECTION 1: PLAN (to be completed by Agent)

NOTE: For ALL sections, ONLY complete the Applicant B information if second applicant also applying

APPLICANT	**APPLICANT B**
Medicare Supplement Plan	**Medicare Supplement Plan**
☐A ☐F ☐G ☐N	☐A ☐F ☐G ☐N
Requested Effective Date:	Requested Effective Date:
Mail Policy To: ☐ Insured ☐ Agent	Mail Policy To: ☐ Insured ☐ Agent

SECTION 2: APPLICANT INFORMATION - PLEASE 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.	Home Phone No.
E-mail Address	E-mail Address
Date of Birth: Current Age _____	Date of Birth: Current Age _____
☐ Male ☐ Female State of Birth:	☐ Male ☐ Female State of Birth:
Social Security No.	Social Security No.
Medicare Health Insurance Card No. or Medicare Beneficiary Identifier	Medicare Health Insurance Card No. or Medicare Beneficiary Identifier

SECTION 3: PLEASE ANSWER ALL QUESTIONS COMPLETELY

	Applicant	Applicant B
Have you received a copy of the **Guide to Health Insurance for People with Medicare** and the **Outline of Coverage**?	☐ Yes ☐ No	☐ Yes ☐ No
To the Best of Your Knowledge:		
1. Are you covered under Medicare Part A?	☐ Yes ☐ No	☐ Yes ☐ No
If "YES," what is your Part A effective date? _____ (Applicant) / _____ (Applicant B)		
If "NO," what is your eligibility date? _____ (Applicant) / _____ (Applicant B)		
2. Are you covered under Medicare Part B or have you enrolled in Medicare Part B in the last six months?	☐ Yes ☐ No	☐ Yes ☐ No
If "YES," what is your Part B effective date? _____ (Applicant) / _____ (Applicant B)		
If "NO," indicate date you plan to enroll. _____ (Applicant) / _____ (Applicant B)		
3. Have you turned 65 in the last six months or will you turn 65 within the next six months?	☐ Yes ☐ No	☐ Yes ☐ No

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.**

SECTION 4: FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.

	Applicant	Applicant B
To the Best of Your Knowledge:		
1. Are you applying during a Guaranteed Issue period?	☐ Yes ☐ No	☐ Yes ☐ No
(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 inforce?	☐ Yes ☐ No	☐ Yes ☐ No
(a) If "YES," with what company and what plan do you have?		

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

	Applicant	Applicant B
(b) If "YES," do you intend to replace your current Medicare Supplement policy/certificate with this policy?	☐ Yes ☐ No	☐ Yes ☐ No
(c) If "YES," indicate termination date: _____ (Applicant) / _____ (Applicant B)		
(d) **If "YES," have you received a copy of the replacement notice?**	☐ Yes ☐ No	☐ Yes ☐ No
If you have had any other Medicare plan coverage as referenced below, not to include Medicare Supplement, please complete questions (a-e) 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) Was this your first time in this type of Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
(d) Did you drop a Medicare Supplement or Medicare Select policy/certificate to enroll in this Medicare plan?	☐ Yes ☐ No	☐ Yes ☐ No
(e) Is your former Medicare Supplement or Medicare Select policy/certificate still available?	☐ Yes ☐ No	☐ Yes ☐ No

4. Have you had coverage under any 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.)	☐ Yes ☐ No	☐ Yes ☐ No

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

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

SECTION 5: HOUSEHOLD PREMIUM DISCOUNT INFORMATION

You may be eligible for a policy with a lower premium rate based on your answers to the questions in this section.

1. Do you currently have a household resident (at least one, no more than 3) who is age 50 or older: a. with whom you have continuously resided for the past 12 months, or to whom you are either married or with whom you are in a civil union partnership; or	☐ Yes ☐ No	☐ Yes ☐ No
b. Who has an existing Medicare Supplement policy, or is applying for such a policy, with Sentinel Security Life Insurance Company?	☐ Yes ☐ No	☐ Yes ☐ No
2. If you answered "YES" to Question 1a or 1b above, please fill out the following information about the household resident, except if both applicants are applying for coverage on this application.		

Name (First/Middle/Last):		
Policy Number:	Social Security Number:	Date of Birth:
Name (First/Middle/Last):		
Policy Number:	Social Security Number:	Date of Birth:

SECTION 6: BILLING INFORMATION

Initial Premium (including app fee) $ _____ + $ _____ = $ _____ Amount Collected: _____ Renewal Premium $ _____	Initial Premium (including app fee) $ _____ + $ _____ = $ _____ Amount Collected: _____ Renewal Premium $ _____
Select Premium Payment Option: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ ACH Monthly (direct monthly not available)	Select Premium Payment Option: ☐ Annual ☐ Semi-annual ☐ Quarterly ☐ ACH Monthly (direct monthly not available)

I would like my monthly premium 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 # (9 digits):	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

SECTION 7: If applying during Open Enrollment or a Guaranteed Issue period, SKIP SECTION 7 and GO TO SECTION 8. Only include information from the past seven years unless otherwise specified. If NOT applying during Open Enrollment or a Guaranteed Issue period, PLEASE ANSWER ALL QUESTIONS. If either you or Applicant B answer "YES" to any of the following questions, 1-14 or 15A-E, that person is not eligible for Medicare Supplement coverage.

	Applicant	Applicant B
1. Are you currently hospitalized, in a nursing home or assisted living facility, receiving hospice or home health care; or, are you bedridden, wheelchair bound, using oxygen or require the use of a motorized device?	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past 7 years, have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorder?	☐ Yes ☐ No	☐ Yes ☐ No
3. In the past 7 years, have you been diagnosed with Parkinson's Disease, systemic lupus, scleroderma, myasthenia gravis, multiple or lateral sclerosis, osteoporosis with related fractures, cirrhosis or chronic hepatitis?	☐ Yes ☐ No	☐ Yes ☐ No
4. In the past 7 years, have you been diagnosed with or taken medication for Alzheimer's Disease, dementia or any other cognitive disorder?	☐ Yes ☐ No	☐ Yes ☐ No
5. In the past 7 years, 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. Within the past 24 months have you been treated for or been advised by a physician to have treatment for internal cancer, alcohol or drug use, mental or nervous disorder requiring psychiatric care or have you had an amputation caused by disease?	☐ Yes ☐ No	☐ Yes ☐ No
7. Within the past 24 months 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 cardiomyopathy, stroke, Transcient Ischemic Attack (TIA) or heart rhythm disorder?	☐ Yes ☐ No	☐ Yes ☐ No
8. Within the past 24 months 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
9. Has a physician advised you to have cataract surgery in the next 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
10. In the past 7 years, has a physician advised you to have surgery, medical tests, treatment or therapy that has not been performed?	☐ Yes ☐ No	☐ Yes ☐ No
11. Have you been hospital confined three or more times in the last 24 months?	☐ Yes ☐ No	☐ Yes ☐ No
12. In the past 7 years, have you had an organ transplant or been advised by a physician to have an organ transplant?	☐ Yes ☐ No	☐ Yes ☐ No
13. In the past 7 years, have you been medically diagnosed with, treated for, or had surgery for Chronic Kidney Disease, kidney failure, or had Kidney Disease requiring dialysis?	☐ Yes ☐ No	☐ Yes ☐ No
14. In the past 7 years, have you been diagnosed with or had any known symptoms of diabetes that has ever required more than 50 units of insulin daily?	☐ Yes ☐ No	☐ Yes ☐ No
15. In the past 7 years, have you been diagnosed with or had any known symptoms of diabetes? If "YES", answer 15A-15E	☐ Yes ☐ No	☐ Yes ☐ No
A. Neuropathy or numbness in your hands, feet or legs?	☐ Yes ☐ No	☐ Yes ☐ No
B. Retinopathy or eye disorder (other than cataracts)?	☐ Yes ☐ No	☐ Yes ☐ No
C. Kidney Disease?	☐ Yes ☐ No	☐ Yes ☐ No
D. Skin ulcers or had an amputation?	☐ Yes ☐ No	☐ Yes ☐ No
E. Heart disorder (including high blood pressure), poor circulation or Peripheral Vascular Disease, history of stroke or TIA?	☐ Yes ☐ No	☐ Yes ☐ No
16. Have you used tobacco in any form, an electronic cigarette (e-cig) or other nicotine delivery product in the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
17. Are you applying for coverage because you have been diagnosed or treated for End Stage Renal Disease (ESRD) or Kidney Disease requiring dialysis?	☐ Yes ☐ No	☐ Yes ☐ No

Applicant	Applicant B
Height / Weight: Ft. _____ In. _____ Lbs. _____	Height / Weight: Ft. _____ In. _____ Lbs. _____

ADDITIONAL INFORMATION: PART 7- CON'T HEALTH/MEDICAL QUESTIONS

18. Are you taking or have you taken any prescription or over-the-counter medications within the past 24 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)
	Medication Name (copy off pharmacy label)	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Frequency and Dosage	
	Diagnosis/Condition	

IF ADDITIONAL SPACE IS REQUIRED ATTACH SEPARATE SHEET

SECTION 8: 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 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 understand a telephone interview may be necessary to verify or supplement information given to the Company on this application. 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.

Any person who knowingly or willingly presents a false or fraudulent claim for payment for a loss or benefit or knowingly or willingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I wish to apply for a Medicare Supplement insurance policy. I represent that my answers and statements on this application are true and complete to the best of my knowledge and belief. I understand that the policy applied for will not take effect until it is issued by us and all of the following requirements are met: (a) the policy is delivered and accepted, each applicant will receive a separate policy; (b) my policy benefits start no earlier than my Medicare effective date; (c) the first full premium has been paid according to the mode of payment specified in the application, and (d) my application has been approved by Sentinel Security Life Insurance Company.

Dated at _____, on _____, _____
City, State Month Day Year

_____ _____
Applicant's Signature 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)

_____ _____
PRODUCER NUMBER/(STAMP) PRODUCER NUMBER/(STAMP)

SECTION 9: AGENT SUPPLEMENT

List any other health insurance policies/certificates you have sold to the applicant.

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

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 inforce.

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

SECTION FOR ADDITIONAL COMMENTS

APPLICANT (please attach a separate sheet if needed)	**APPLICANT B** (please attach a separate sheet if needed)

MEDICARE SUPPLEMENT 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 Home Office and a policy is issued.

_____ _____ _____

Producer's Name (please print) Producer's Signature Date

LEAVE WITH APPLICANT

Sentinel Security Life Insurance Company
PO Box 27248 Salt Lake City, UT 84127-0248
1-800-247-1423

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) obtaining reinsurance; 3) determining or fulfilling responsibility for coverage and provision of benefits; 4) and administering coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, MIB, Inc., 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 its assigns as necessary 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 authorize Sentinel Security Life Insurance Company, or its reinsurers, to make a brief report of my protected personal health information to MIB, Inc.

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

RETURN TO COMPANY

MEDICARE SUPPLEMENT REPLACEMENT

PO Box 27248 Salt Lake City, UT 84127-0248 • Toll Free 800-247-1423 • Fax 888-433-4795

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, 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 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 inforce. 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 Agent / Broker / Other Representative	Print Name and Address of Issuer / Agent / Broker
Signature of Applicant	Signature of Spouse, if applying
Date	

RETURN TO COMPANY

MEDICARE SUPPLEMENT REPLACEMENT

PO Box 27248 Salt Lake City, UT 84127-0248 • Toll Free 800-247-1423 • Fax 888-433-4795

Notice to Applicant regarding replacement of Medicare Supplement insurance or Medicare Advantage

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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, 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 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 inforce. 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 Agent / Broker / Other Representative	Print Name and Address of Issuer / Agent / Broker
Signature of Applicant	Signature of Spouse, if applying
Date	

LEAVE WITH APPLICANT

AGENT CERTIFICATION

I the undersigned insurance agent certify; **THAT,** I have taken an application for:

Primary Insured: _____
Medicare Supplement

- ☐ **Plan A**
- ☐ **Plan F**
- ☐ **Plan G**
- ☐ **Plan N**

Spouse: _____
Medicare Supplement

- ☐ **Plan A**
- ☐ **Plan F**
- ☐ **Plan G**
- ☐ **Plan N**

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 agent 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 ☐ 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 Agent

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

_____
Name of Agency

_____
Signature of Applicant

_____
Address of Agent / Agency

_____
Signature of Spouse, if applying

_____
Phone Number

RETURN TO COMPANY

PO Box 27248 Salt Lake City, UT 84127-0248 • Toll Free 800-247-1423 • Fax 888-433-4795

CALCULATE YOUR PREMIUM

Calculate Your Premium *Medicare Supplement*

Medicare Supplement Plan

Before you begin: If you are 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.**	$128.52 + $25.00 = $153.52 Example shows initial payment (monthly schedule).		

COMPLETE AND RETURN WITH APPLICATION

HEIGHT AND WEIGHT CHART

To determine whether you may purchase coverage, locate your height, then weight in the chart below. If your weight is not in the Standard column, we are sorry, you are not eligible for coverage at this time. If your weight is located in the Standard column, you may proceed in completing the application.

MEDICARE SUPPLEMENT

	Decline	Standard	Decline
Height	Weight	Weight	Weight
4′ 2″	< 54	54 – 145	146 +
4′ 3″	< 56	56 – 151	152 +
4′ 4″	< 58	58 – 157	158 +
4′ 5″	< 60	60 – 163	164 +
4′ 6″	< 63	63 – 170	171 +
4′ 7″	< 65	65 – 176	177 +
4′ 8″	< 67	67 – 182	183 +
4′ 9″	< 70	70 – 189	190 +
4′ 10″	< 72	72 – 196	197 +
4′ 11″	< 75	75 – 202	203 +
5′ 0″	< 77	77 – 209	210 +
5′ 1″	< 80	80 – 216	217 +
5′ 2″	< 83	83 – 224	225 +
5′ 3″	< 85	85 – 231	232 +
5′ 4″	< 88	88 – 238	239 +
5′ 5″	< 91	91 – 246	247 +
5′ 6″	< 93	93 – 254	255 +
5′ 7″	< 96	96 – 261	262 +
5′ 8″	< 99	99 – 269	270 +
5′ 9″	< 102	102 – 277	278 +
5′ 10″	< 105	105 – 285	286 +
5′ 11″	< 108	108 – 293	294 +
6′ 0″	< 111	111 – 302	303 +
6′ 1″	< 114	114 – 310	311 +
6′ 2″	< 117	117 – 319	320 +
6′ 3″	< 121	121 – 328	329 +
6′ 4″	< 124	124 – 336	337 +
6′ 5″	< 127	127 – 345	346 +
6′ 6″	< 130	130 – 354	355 +
6′ 7″	< 134	134 – 363	364 +
6′ 8″	< 137	137 – 373	374 +
6′ 9″	< 140	140 – 382	383 +
6′ 10″	< 144	144 – 392	393 +
6′ 11″	< 147	147 – 401	402 +
7′ 0″	< 151	151 – 411	412 +
7′ 1″	< 155	155 – 421	422 +
7′ 2″	< 158	158 – 431	432 +
7′ 3″	< 162	162 – 441	442 +
7′ 4″	< 166	166 – 451	452 +

ACH FAX TRANSMITTAL GUIDE

Initial Premiums Paid through ACH (Automated Clearing House)
Medicare Supplement applications may have their initial premium automatically deducted from their checking or savings account through the specific Electronic Funds Transfer (EFT) process. When they do, you may fax the application and required forms instead of mailing them.

Follow these easy steps to submit Medicare Supplement applications using ACH for the initial premium:

STEP 1 – COMPLETE THE AUTHORIZATION FOR ELECTRONIC FUNDS TRANSFER SECTION ON THE APPLICATION.

Applicants wishing to pay electronically complete the appropriate Medicare Supplement Authorization for Electronic Funds Transfer section on the application.

STEP 2 – FAX THE FOLLOWING ITEMS TO THE DEDICATED LINE FOR ACH PAYMENTS AT (888) 433-4795

1) ACH fax transmittal cover sheet on the back of this form

2) Medicare Supplement Application and other required forms including authorization for EFT

If you fax the application, do not mail it as processing errors occur and additional charges could result in the duplication.

For producer use only. Not for use with the general public.

ACH FAX TRANSMITTAL

FAX TRANSMITTAL

FOR USE WITH EFT MONTHLY PREMIUM APPLICATIONS ONLY

1-888-433-4795

Use this fax number only for applications and new business documents. Applications faxed to any other number can cause delays in processing your business.

Please complete the following information:

Total number of pages being faxed including this cover sheet _____

Producer Name _____

Producer Number _____

Producer Phone Number / Producer Fax Number _____

Comments _____

NOTES

Sentinel Security Life Insurance Company

Since 1948, families have counted on Sentinel Security Life Insurance Company during their time of need. The Company was originally established to provide families a way of funding funeral expenses and burial costs. Through our final expense life insurance product, we have been honored to provide peace of mind to families for well over half a century.

Today, Sentinel offers a strong senior market portfolio including Life, Medicare Supplement and Annuity products. We continue to develop new products while improving existing products and services to better protect our customers.

Sentinel has a long history of financial strength and stability that has afforded us the opportunity to invest wisely in the growth of our company. Our strength lies not only in the quality of our insurance products, but also the level of service we provide to our policyholders, agents, and shareholders. We invite you to learn more about our company by visiting www.sslco.com or by calling 800-247-1423.

SENTINEL SECURITY LIFE INSURANCE COMPANY
PO BOX 27248 SALT LAKE CITY, UTAH 84127-0248