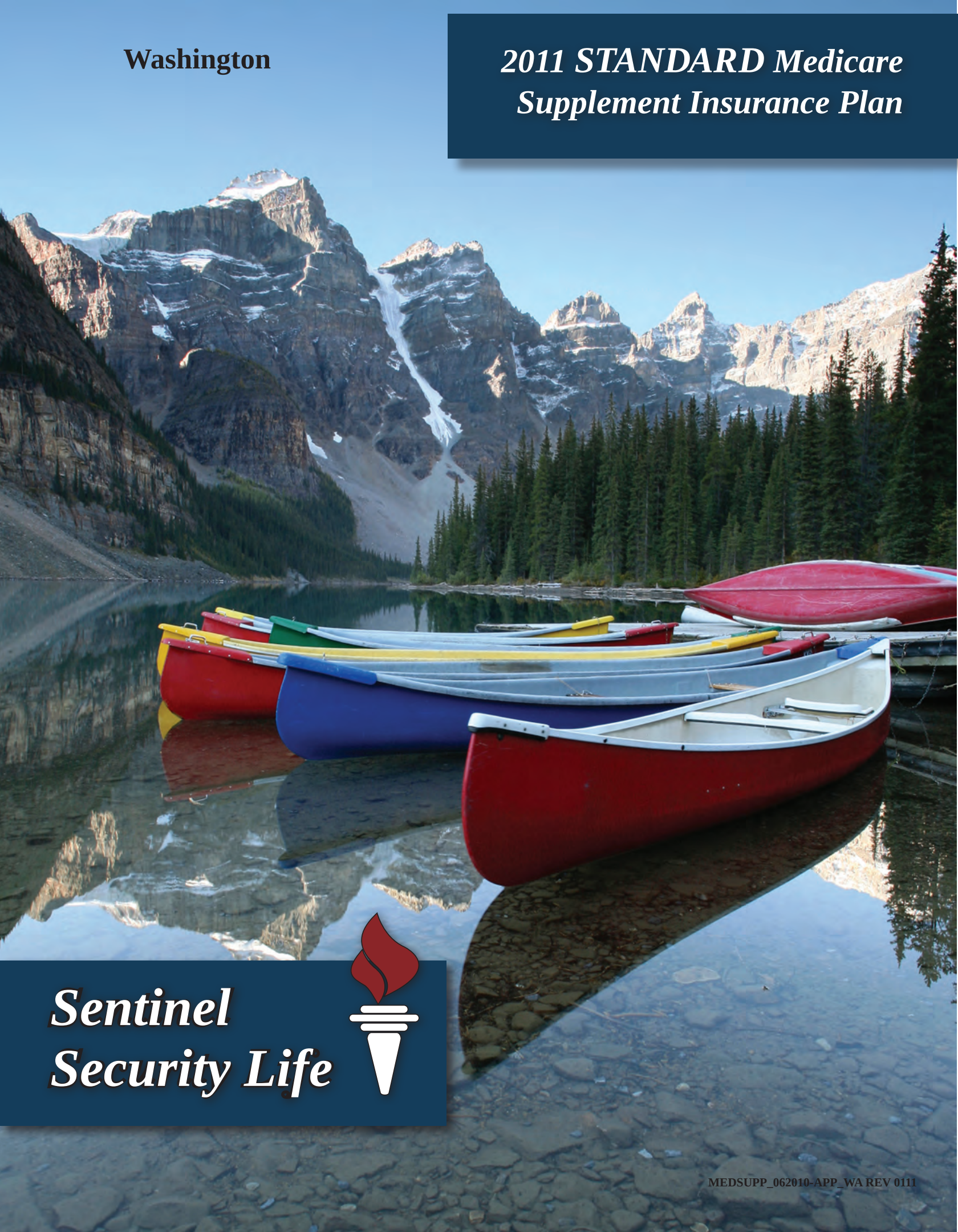
Washington

2011 STANDARD Medicare Supplement Insurance Plan



Sentinel Security Life

MEDSUPP_062010-APP_WA REV 0111

2011 Medicare Supplement Insurance Plans On Your Team

You can rely on Sentinel Security Life's Medicare Supplement Plans to help pay your Medicare Parts A and B charges Medicare doesn't cover.

What's more, you have:

Five plans from which to select the coverage that best meets your needs.

Your choice of physicians and specialists for your personalized care.

The option to use any hospital or medical facility.

Virtually no claims paperwork to file.

Put a Sentinel Security Life Medicare Supplement Plan on your team today.

About Us

A.M. Best Co, a global full-service credit rating organization dedicated to serving the financial and health care service industries, has affirmed the financial strength rating of B++ (Good) for Sentinel Security Life Insurance Company. This rating applies only to the overall financial status of the company and is not a recommendation of the specific policy provisions, rates or practices of the company.

Medicare Supplement insurance is underwritten by:

Sentinel Security Life Insurance Company.
2121 South State Street
Salt Lake City, UT 84115

Choose the Medicare Supplement Plan that's Right for You

Choose the Medicare Supplement Plan that's Right for You

Service and Supplies	Medicare Pays	Plan A Pays	Plan B Pays	Plan C Pays	Plan D Pays	Plan F Pays
Medicare Part A Hospital Coverage						
Deductible	Nothing		$1,132	$1,132	$1,132	$1,132
First 60 Days	100%					
Co-Insurance 61-90 days	All but $283 a Day	$283 a Day	$283 a Day	$283 a Day	$283 a Day	$283 a Day
Co-Insurance 91-150 days (Lifetime Reserve)	All but $566 a Day	$566 a Day	$566 a Day	$566 a Day	$566 a Day	$566 a Day
Extended Hospital Coverage (Up to an additional 365 days in your lifetime)	Nothing	Eligible expenses	Eligible expenses	Eligible expenses	Eligible expenses	Eligible expenses
Benefit for Blood	All but Three Pints	Three Pints	Three Pints	Three Pints	Three Pints	Three Pints
Hospice Care						
	All but limited Co-Insurance for outpatient drugs and inpatient respite care	Medicare Co-Insurance	Medicare Co-Insurance	Medicare Co-Insurance	Medicare Co-Insurance	Medicare Co-Insurance
Skilled Nursing Facility Care						
First 20 days	100%					
Co-Insurance 21-100 days	All but $141.50 a day			$141.50 a day	$141.50 a day	$141.50 a day
Medicare Part B Physicians's Service and Supplies						
Deductible	Nothing			$162		$162
Co-Insurance	80%	20%	20%	20%	20%	20%
Excess Benefits	Nothing					100% up to Medicare's Limit
Benefit for Blood	All but Three Pints	Three Pints	Three Pints	Three Pints	Three Pints	Three Pints
Additional Benefits*						
Emergency Care received outside the U.S.	Nothing			80% to Lifetime Max of $50,000	80% to Lifetime Max of $50,000	80% to Lifetime Max of $50,000
* Refer to the next page and your outline of coverage for more information.		YOUR PREMIUM $_____	YOUR PREMIUM $_____	YOUR PREMIUM $_____	YOUR PREMIUM $_____	YOUR PREMIUM $_____

Medicare Part A Hospital Coverage

The Sentinel Security Standard Plan pays the $1,132 Part A (inpatient) deductible for plans B, C, D & F for each benefit period.

First 60-days
After the Part A Deductible, Medicare pays all eligible expenses for services from your first through 60th day of hospital confinement. Services include semi-private room and board, general nursing and miscellaneous hospital services and supplies.

Co-Insurance
Sentinel Security Standard Plans A, B, C, D & F pay $283 a day when you are hospitalized from the 61st day through the 90th day. When you are hospitalized from the 91st day through the 150th day, Sentinel Security Standard Plans pay $566 a day for each Lifetime Reserve day used.

Extended Hospital Coverage
If you are in the hospital longer than 150 days during a benefit period and you have exhausted your 60 days of Medicare Lifetime Reserve the Sentinel Security Standard Plans A, B, C, D & F pay the Part A Medicare eligible expenses for hospitalization, paid at the same rate Medicare would have paid had Medicare Part A hospital days not been exhausted, subject to a lifetime maximum benefit of an additional 365 days.

Benefit for Blood
Medicare has one calendar year deductible for blood that is the cost of the first three pints. Sentinel Security Standard Plans A, B, C, D & F pay the deductible.

Skilled Nursing Facility Care
Medicare pays all eligible expenses for the first 20 days. Sentinel Security Standard Plans C, D & F pay up to $141.50 from the 21st through the 100th day during which you receive skilled nursing care. You must enter a Medicare certified skilled nursing facility within 30 days of being hospitalized for at least three days.

Hospice Care
Medicare pays all but a very limited Co-Insurance for outpatient drugs and inpatient respite care. Sentinel Security Standard Plans A, B, C, D & F pay the Co-Insurance.

Medicare Part B Physician Services and Supplies

Deductible
Sentinel Security Standard Plans C & F pay the $162 calendar-year deductible.

Co-Insurance
After the Part B Deductible, Sentinel Security Standard Plans A, B, C, D & F pay 20% of eligible expenses for physician's services, supplies, physical and speech therapy and ambulance service.

For hospital outpatient services, the co-payment amount will be paid under a prospective payment system. If this system is not used, then 20% of eligible expenses will be paid.

Excess Benefits
Your bill for Part B services and supplies may exceed the Medicare eligible expense. When that occurs, Sentinel Security Standard Plan F pays 100% up to the charge limitation established by Medicare.

Benefit for Blood
Medicare has one calendar year deductible for blood that is the cost of the first three pints. Sentinel Security Standard Plans A, B, C, D & F pay the deductible.

Additional Benefits*

Emergency Care Received Outside the U.S.
After you pay a $250 calendar-year deductible, Sentinel Security Standard Plans C, D & F pay you 80% of eligible expenses for care which begins during the first 60 days of a trip up to a lifetime maximum of $50,000. Benefits are payable for health care you need because of a covered injury or illness.

Your Sentinel Plan™

Medicare Supplement Plans

A Sentinel Security Standard Medicare Supplement insurance policy helps pay eligible expenses not paid for by Medicare Part A and Medicare Part B. There may be charges that exceed what Medicare and your Sentinel Security Standard insurance policy will pay.

"Medicare Eligible Expenses" means expenses covered by Medicare to the extent recognized as reasonable and medically necessary by Medicare.

Sentinel Security Standard Medicare Supplement will not pay for:

- Any expense incurred before your Policy Date
- Services for which no charge is made
- Expenses paid by Medicare
- Hospital or skilled nursing facility confinement incurred during a Medicare Part A benefit period that begins while this policy is not in force
- Loss or expense that is payable under any other Medicare supplement insurance policy or certificate

Medicare Part A Eligible Expenses for Hospital/ Skilled Nursing Facility Care include expenses for semi-private room and board, general nursing and miscellaneous services and supplies.

A Benefit Period begins the first full day you are hospitalized and ends when you have not been in a hospital or skilled nursing facility for 60 consecutive days.

Medicare Part B Eligible Expenses for Medical Services include expenses for physician's services, hospital outpatient services and supplies, physical and speech therapy, and ambulance service.

Co-Insurance is the portion of the eligible expense not paid by Medicare and paid by Sentinel Security Standard Medicare supplement.

Benefits are paid to you, your hospital or doctor.

You have 31 days from your renewal date to pay your premium. Your policy will stay inforce during this 31-day grace period.

Your Policy is guaranteed renewable. Your policy cannot be canceled. It will be renewed as long as the premiums are paid on time and the information on your application is correct.

You cannot be singled out for a rate increase no matter how many times you receive benefits. Your premium changes only when the same premium change is made on all inforce Sentinel Security Standard policies of the same form issued to persons of your classification in the same geographic area of your state.

This Is A Brief Description of your coverage. This brochure must be accompanied by the Outline of Coverage. For a complete description of benefits, exceptions and limitations, please read your outline of coverage and your policy.

Sentinel Security Life nor its Medicare supplement insurance policy are connected with or endorsed by the US government or the federal Medicare program.

This is a solicitation of insurance and a producer will contact you by telephone.

SENTINEL SECURITY LIFE INSURANCE COMPANY

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

Benefit Plans A, B, C#, D# and F#

Outline of Medicare Supplement Coverage – Cover Page

This chart shows the benefits included in each of the standard Medicare supplement plans. Every company must make Plan "A" available. Some plans may not be available in your state. Plans E, H, I and J are no longer available for sale.

Basic Benefits:

Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.

Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses), or copayment for hospital outpatient services.

Plans K, L and N require insured to pay a portion of Part B coinsurance or copayments.

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

A	B	C	D	F	F*	G
Basic, including 100% Part B Co-Insurance	Basic, including 100% Part B Co-Insurance	Basic, including 100% Part B Co-Insurance	Basic, including 100% Part B Co-Insurance	Basic, including 100% Part B Co-Insurance		Basic, including 100% Part B Co-Insurance
		Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance		Skilled Nursing Facility Co-Insurance
	Part A Deductible	Part A Deductible	Part A Deductible	Part A Deductible		Part A Deductible
		Part B Deductible		Part B Deductible		
				Part B Excess (100%)		Part B Excess (100%)
		Foreign Travel Emergency	Foreign Travel Emergency	Foreign Travel Emergency		Foreign Travel Emergency

* Plan F also has an option called a high deductible Plan F. This high deductible plan pays the same benefits as Plan F after one has paid a calendar year $2,000 deductible. Benefits from high deductible Plan F will not begin until out-of-pocket expenses exceed $2,000. Out-of-pocket expenses for this deductible are expenses that would ordinarily be paid by the policy. These expenses include Medicare deductibles for Part A and Part B, but do not include the plan's separate foreign travel emergency deductible.

K	L	M	N
Basic, Including 100% Part B Co-Insurance; other basic benefits paid at 50%	Basic, Including 100% Part B Co-Insurance; other basic benefits paid at 75%	Basic, Including 100% Part B Co-Insurance	Basic, including 100% Part B Co-Insurance, except up to $20 copayment for office visit, and up to $50 copayment for ER
50% Skilled Nursing Facility Co-Insurance	75% Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance	Skilled Nursing Facility Co-Insurance
50% Part A Deductible	75% Part A Deductible	50% Part A Deductible	Part A Deductible
		Foreign Travel Emergency	Foreign Travel Emergency
Out-of-Pocket limit $4640; paid at 100% after limit reached	Out-of-Pocket limit $2320; paid at 100% after limit reached		

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

PREMIUM INFORMATION

We, Sentinel Security Life Insurance Company, can only raise Your premium if (a) We change the premium rates which apply to all policies of this form issued by Us and in-force in Your state; (b) coverage under Medicare changes; or (c) You move to a different ZIP code location. We will send You the advance written notice required by your state when We change the premium rates for all policies of this form issued by Us and in-force in Your state.

DISCLOSURES

Use this Outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

This is only an Outline, describing Your Policy's most important features. The Policy is Your insurance contract. You must read the Policy itself to understand all of the rights and duties of both You and Your insurance company.

30-DAY RIGHT TO RETURN POLICY

If You find that You are not satisfied with Your Policy, You may return it to Sentinel Security Life Insurance Company, P.O. Box 16960, Clearwater, FL 33766-6960. If You send the policy back to Us within 30 days after You receive it, We will treat the policy as if it had never been issued and return all of Your premiums.

POLICY REPLACEMENT

If You are replacing another health insurance Policy, do NOT cancel it until You have actually received Your new Policy and are sure You want to keep it.

NOTICE

This Policy may not fully cover all of Your medical costs. Neither Sentinel Security Life Insurance Company nor its agents are connected with Medicare. This Outline of Coverage does not give all the details of Medicare coverage. Contact Your local Social Security Office or consult *Medicare and You* for more details.

COMPLETE ANSWERS ARE VERY IMPORTANT

When You fill out the application for the new Policy, be sure to answer truthfully and completely all questions about Your medical and health history. The Company may cancel Your Policy and refuse to pay any claims if You leave out or falsify important medical information.

Review the application carefully before You sign it. Be certain that all information has been properly recorded.

RENEWABILITY

This Policy is guaranteed renewable for life.

SENTINEL SECURITY LIFE INSURANCE COMPANY

*MONTHLY RATES**

STANDARD NON-TOBACCO and TOBACCO
ZIP CODES: ALL ZIPs

	Unisex				
Community Rated	Std. Plan A SSLA10ST-WA	Std. Plan B SSLB10ST-WA	Std. Plan C SSLC10ST-WA	Std. Plan D SSLD10ST-WA	Std. Plan F SSLF10ST-WA
All Ages	$126.36	$140.84	$174.19	$150.36	$176.02

To obtain annual, semiannual, or quarterly premiums, multiply the Monthly Premiums Amount by 12, 6, or 3, respectively.

PLAN A MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN A PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$0	$1,132 (Part A Deductible)
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
• Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	 $0 $0	 100% of Medicare Eligible Expenses $0	 $0** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days 21st thru 100th day 101st day and after	All approved amounts All but $141.50 a day $0	$0 $0 $0	$0 Up to $141.50 a day All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited coinsurance for outpatient drugs and inpatient respite care	Medicare copayment / coinsurance	$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN A MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once You have been billed $162 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $162 of Medicare approved amounts* (the Part B Deductible)	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare approved amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
- First $162 of Medicare-approved amounts*	$0	$0	$162 (Part B Deductible)
- Remainder of Medicare-approved amounts	80%	20%	$0

PLAN B MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
• Once lifetime reserve days are used: - Additional 365 days - Beyond the additional 365 days	 $0 $0	 100% of Medicare Eligible Expenses $0	 $0** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $141.50 a day	$0	Up to $141.50 a day
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited Co-Insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN B MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once You have been billed $162 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $162 of Medicare approved amounts* (the Part B Deductible)	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare approved amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
- First $162 of Medicare-approved amounts*	$0	$0	$162 (Part B Deductible)
- Remainder of Medicare-approved amounts	80%	20%	$0

PLAN C MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $566 a day		$0
• Once lifetime reserve days are used:		$566 a day	
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited Co-Insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN C MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once You have been billed $162 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $162 of Medicare approved amounts* (the Part B Deductible)	$0	$162 (Part B Deducticble)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare approved amounts*	$0	$162 (Part B Deducticble)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
- First $162 of Medicare-approved amounts*	$0	$162 (Part B Deducticble)	$0
- Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN D MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days - Beyond the additional 365 days	$0 $0	100% of Medicare Eligible Expenses $0	$0** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited Co-Insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN D MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once You have been billed $162 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $162 of Medicare approved amounts* (the Part B Deductible)	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	$0	All costs
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare approved amounts*	$0	$0	$162 (Part B Deductible)
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
- First $162 of Medicare-approved amounts*	$0	$0	$162 (Part B Deductible)
- Remainder of Medicare-approved amounts	80%	20%	$0

PLAN D

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

PLAN F MEDICARE (PART A) – HOSPITAL SERVICES – PER BENEFIT PERIOD

* A benefit period begins on the first day You receive service as an inpatient in a hospital and ends after You have been out of the hospital and have not received skilled care in any other facility for 60 days in a row.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies			
First 60 days	All but $1,132	$1,132 (Part A Deductible)	$0
61st thru 90th day	All but $283 a day	$283 a day	$0
91st day and after:			
• While using 60 lifetime reserve days	All but $566 a day	$566 a day	$0
• Once lifetime reserve days are used:			
- Additional 365 days	$0	100% of Medicare Eligible Expenses	$0**
- Beyond the additional 365 days	$0	$0	All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital.			
First 20 days	All approved amounts	$0	$0
21st thru 100th day	All but $141.50 a day	Up to $141.50 a day	$0
101st day and after	$0	$0	All Costs
BLOOD			
First 3 pints	$0	3 pints	$0
Additional amounts	100%	$0	$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited Co-Insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	$0

****NOTICE:** When Your Medicare Part A hospital benefits are exhausted, the insurer stands in place of Medicare and will pay whatever amount Medicare would have paid for up to an additional 365 days as provided in the policy's "Core Benefits." During this time the hospital is prohibited from billing You for the balance based on any difference between its billed charges and the amount Medicare would have paid.

PLAN F MEDICARE (PART B) – MEDICAL SERVICES – PER CALENDAR YEAR

* Once You have been billed $162 of Medicare-approved amounts for covered services (which are noted with an asterisk), Your Part B Deductible will have been met for the calendar year.

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.			
First $162 of Medicare approved amounts* (the Part B Deductible)	$0	$162 (Part B Deducticble)	$0
Remainder of Medicare-approved amounts	Generally 80%	Generally 20%	$0
Part B Excess Charges (Above Medicare-approved amounts)	$0	100%	$0
BLOOD			
First 3 pints	$0	All costs	$0
Next $162 of Medicare approved amounts*	$0	$162 (Part B Deducticble)	$0
Remainder of Medicare-approved amounts	80%	20%	$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES	100%	$0	$0

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
• Medically necessary skilled care services and medical supplies	100%	$0	$0
• Durable medical equipment			
- First $162 of Medicare-approved amounts*	$0	$162 (Part B Deducticble)	$0
- Remainder of Medicare-approved amounts	80%	20%	$0

OTHER BENEFITS – NOT COVERED BY MEDICARE

FOREIGN TRAVEL – NOT COVERED BY MEDICARE			
Medically necessary emergency care services beginning during the first 60 days of each trip outside the USA			
First $250 each calendar year	$0	$0	$250
Remainder of charges	$0	80% to a lifetime maximum benefit of $50,000	20% and amounts over the $50,000 lifetime maximum

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.	
APPLICANT	**APPLICANT B**
Medicare Supplement Plan	Medicare Supplement Plan
☐ A ☐ B ☐ C ☐ D ☐ F	☐ A ☐ B ☐ C ☐ D ☐ F
Requested Effective Date	Requested Effective Date
Mail Policy To: ☐ Insured ☐ Producer	Mail Policy To: ☐ Insured ☐ 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 (_____)_____ (area code)	Home Phone No (_____)_____ (area code)
Current Age _____ Date of Birth_____ mo/day/ yr	Current Age _____ Date of Birth_____ mo/day/ yr
Male ☐ Female ☐ State of Birth_____	Male ☐ Female ☐ 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.

	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 ☐ No ☐	Yes ☐ No ☐
2. Have you used tobacco in any form in the past 12 months?	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?	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. Did you turn age 65 in the last six months?	Yes ☐ No ☐	Yes ☐ No ☐
4. Did you enroll in Medicare Part B in the last six months?	Yes ☐ No ☐	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 ☐	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 ☐ No ☐	Yes ☐ No ☐

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?	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-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_____ (Applicant) / START_____ END_____ (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 ☐ 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)

	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	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 ☐ 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)
	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 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.
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)

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

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)
	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	
	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)

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

PRODUCER CERTIFICATION

I the undersigned insurance producer certify;

THAT, I have taken an application for:

Primary Insured:		**Spouse:**	
Medicare Supplement	Medicare Select	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 _____
(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.

_____
Name of Agency

_____
Signature of Applicant

_____
Address of Producer / Agency

_____
Signature of Spouse, if applying

_____
Phone Number

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 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

Calculate Your Premium

Medicare Supplement

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.**	**NOT APPLICABLE IN WA.** $128.52 + $25.00 = $153.52 Example shows initial payment (monthly schedule).		

Height and Weight Charts

Eligibility

To determine whether you may purchase coverage, locate your height, then weight in the chart below. If your weight is in the Decline column, we're sorry, you're not eligible for coverage at this time. If your weight is located in the Standard column, you may continue to step 1.

	Decline	Standard	Decline
Hieght	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 +

Sentinel Security Life Insurance Company
Administrative Office
PO Box 16960
Clearwater, FL 33766-6960
Phone: 1-888-510-0668

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 apps 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 (800) 719-1264

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.

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FAX TRANSMITTAL

FOR USE WITH EFT MONTHLY PREMIUM APPLICATIONS ONLY

1-800-719-1264

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 or SSN _____

Producer Phone Number _____

Producer Fax Number _____

Comments _____

_____

_____

_____

_____

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_____

_____

_____

_____

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

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

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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

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.

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

Sentinel Security Life

The Company was organized in 1948 by a group in Utah. Some of the original founders still serve the Company as members of the Board of Directors.

The Company began its operations as Sentinel Mutual Insurance Company. In 1954, the Articles of Incorporation were amended to change the Company to a capital stock insurer and the name was changed to Sentinel Insurance Company. In 1957, the Articles of Incorporation were again amended to change the company's name to its present status as Sentinel Security Life Insurance Company.

In 1962 we acquired Uinta National Insurance Company of Utah and United Reserve Life Company of Montana. In 1965, we acquired National Mutual Insurance Company of Utah.

We are licensed to operate in 23 states. They are Utah, Arizona, California, Colorado, Florida, Hawaii, Idaho, Iowa, Kansas, Louisiana, Minnesota, Montana, Nebraska, Nevada, New Mexico, North Carolina, North Dakota, Oklahoma, Oregon, South Dakota, Texas, Washington and Wyoming.

The Company's goal throughout its history has been to provide the best possible products and services to our policyholders. We take great pride in our prompt customer and claims service. We have a dedicated staff of employees with an average tenure of over 19 years with the Company.

Sentinel Security Life is rated B++ (Good) for financial strength by A.M. Best Company. This rating applies only to the overall financial status of the Company and is not a recommendation of the specific policy provisions, rates or practices of the Company.

Sentinel Security Life Insurance Company
2121 South State St.
Salt Lake City, UT 84115

Administrative Office
P.O. Box 16960
Clearwater, FL 33766-6960

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