

State: Arkansas **Filing Company:** Sentry Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: I Life Consolidation Form
Project Name/Number: Reinstate/Conversion/Reqst for Serv/340-1576

Filing at a Glance

Company: Sentry Life Insurance Company
 Product Name: I Life Consolidation Form
 State: Arkansas
 TOI: L08 Life - Other
 Sub-TOI: L08.000 Life - Other
 Filing Type: Form
 Date Submitted: 10/11/2012
 SERFF Tr Num: SLIN-128723895
 SERFF Status: Closed-Approved-Closed
 State Tr Num:
 State Status: Approved-Closed
 Co Tr Num: 340-1576

 Implementation: On Approval
 Date Requested:
 Author(s): Melissa Barden, Mary Rosicky
 Reviewer(s): Linda Bird (primary)
 Disposition Date: 10/16/2012
 Disposition Status: Approved-Closed
 Implementation Date:

 State Filing Description:

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: I Life Consolidation Form
Project Name/Number: Reinstate/Conversion/Reqst for Serv/340-1576

Filing Company: Sentry Life Insurance Company

General Information

Project Name: Reinstate/Conversion/Reqst for Serv
Project Number: 340-1576
Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Not Filed

Date Approved in Domicile:

Domicile Status Comments: WI is a member of IIPRC. This form will be filed with the Compact rather than filing in WI individually.

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 10/16/2012

State Status Changed: 10/16/2012

Deemer Date:

Created By: Melissa Barden

Submitted By: Melissa Barden

Corresponding Filing Tracking Number:

Filing Description:

SENTRY LIFE INSURANCE COMPANY

NAIC #169-68810

340-1576 Term Conversion, Reinstatement and Request for Service Combination Application

The above referenced new form is being submitted for your review and approval. This form is new and in the final version. This form will replace the following forms: 380-43-1(Rpt 1), Request for Service Application, stamped for approval 08/04/1986; 380-2054(AR-Rpt 3), Application for Conversion of Term Policy, stamped "Filed by Certification" 01/13/2003 and 340-397, Application for Reinstatement, unable to locate approval date. This new form was created to accommodate requests for service, including term conversion and reinstatement requests, as well as the updated MIB language.

To the best of our knowledge and belief, the form submitted is in compliance with the regulations established by the State of Arkansas. The filing includes no assumptions or provisions that unfairly discriminate in availability, rates, benefits or any other way for prospective annuitants of the same class, equal expectation of life and degree of risk. This filing also does not contain any unusual or controversial terms. In addition, form contains no provisions previously disapproved by your Department.

In an effort to make the form as convenient as possible for the policy owner, sections of the form which are not applicable to the specific request would be watermarked as "NOT APPLICABLE". For instance, if the insured/owner was requesting a term conversion, only sections 1) Insured/Owner/Beneficiary Information and 6) Term Conversion of the form would need to be completed; therefore, the remaining sections 2), 3), 4) and 5) would be watermarked as "NOT APPLICABLE". An example has been attached as Supporting Documentation for your convenience.

A Flesch Readability Certification has been included as Supporting Documentation.

Also included under the Supporting Documentation tab is a variable version of the form submitted for your approval. Variable information is indicated by brackets. Variables will not be adjusted to be less favorable than the State of Arkansas allows. A Statement of Variability is included under the Supporting Documentation tab for your convenience.

If you have any questions regarding this filing, please feel free to contact me.

We respectfully request your approval.

State: Arkansas **Filing Company:** Sentry Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: I Life Consolidation Form
Project Name/Number: Reinstate/Conversion/Reqst for Serv/340-1576

Company and Contact

Filing Contact Information

Melissa Barden, Compliance Analyst - Sr. mel.barden@sentry.com
 1800 North Point Drive 715-346-6891 [Phone] 6891 [Ext]
 Stevens Point, WI 54481

Filing Company Information

Sentry Life Insurance Company	CoCode: 68810	State of Domicile: Wisconsin
1800 North Point Drive	Group Code: 169	Company Type: stock
Stevens Point, WI 54481	Group Name: Sentry Insurance	company
(715) 346-6000 ext. [Phone]	Group	State ID Number:
	FEIN Number: 39-6040276	

Filing Fees

Fee Required? Yes
 Fee Amount: \$50.00
 Retaliatory? No
 Fee Explanation: \$50/form
 Per Company: No

Company	Amount	Date Processed	Transaction #
Sentry Life Insurance Company	\$50.00	10/11/2012	63701605

State: Arkansas Filing Company: Sentry Life Insurance Company
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: I Life Consolidation Form
Project Name/Number: Reinstate/Conversion/Reqst for Serv/340-1576

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	10/16/2012	10/16/2012

SERFF Tracking #:

SLIN-128723895

State Tracking #:**Company Tracking #:**

340-1576

State:

Arkansas

Filing Company:

Sentry Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

I Life Consolidation Form

Project Name/Number:

Reinstate/Conversion/Reqst for Serv/340-1576

Disposition

Disposition Date: 10/16/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	340-1576 Combination Administrative Application, Variable		Yes
Supporting Document	340-1576 Combination Administrative Application, Watermarked for Term Conversion		Yes
Supporting Document	Statement of Variability		Yes
Form	I Life Reqst for Serv, Term Conv, Reinst App		Yes

SERFF Tracking #:

SLIN-128723895

State Tracking #:

Company Tracking #:

340-1576

State: Arkansas
TOI/Sub-TOI: L08 Life - Other/L08.000 Life - Other
Product Name: I Life Consolidation Form
Project Name/Number: Reinstate/Conversion/Reqst for Serv/340-1576

Filing Company: Sentry Life Insurance Company

Form Schedule

Lead Form Number: 340-1576

Item No.	Schedule Item Status	Form Number	Form Type	Form Name	Action/ Action Specific Data	Readability Score	Attachments
1		340-1576	AEF	I Life Reqst for Serv, Term Conv, Reinst App	Initial:	46.600	340-1576_Clean_10-09-2012.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages



INDIVIDUAL LIFE INSURANCE REQUEST FOR SERVICE, TERM CONVERSION or REINSTATEMENT APPLICATION

Existing Policy Number: _____

Please work with your Sentry Sales Producer to make any changes or updates to your policy. If you do not have a Sales Producer, please call 800-533-7827, press option 1 and our Home Office staff will assist you in completing these forms.

1. Reinstatement of a Lapsed Policy (**complete sections 1, 3, 4 and 5 only**)
2. Change to an Existing Policy (**complete sections 1, 2, 4 and 5 only**)
A new Life Insurance Application is REQUIRED if the following coverages are being applied for: *Spouse Benefit, Children's Benefit, Family Benefit, Other Insured Benefit, Payor Benefit or Increase in Specified Amount*
3. Term Conversion (**complete sections 1 and 6 only**)

1) Insured/Owner/Beneficiary Information

A) Complete this section with the Insured information.

Insured: _____ Date of Birth: _____
Social Security Number: _____ Daytime Phone Number: _____
Best Time to Call: _____ Home Phone Number: _____
Mailing Address: _____
Residential Address: _____
Email Address (optional): _____

B) Complete this section only if the Insured is not the Policy Owner.

Policy Owner: _____ Date of Birth: _____
Social Security Number: _____ Daytime Phone Number: _____
Best Time to Call: _____ Home Phone Number: _____
Mailing Address: _____
Residential Address: _____
Email Address (optional): _____

C) Complete this section with Beneficiary designations.

- For additional Beneficiaries, please attach a separate list to the end of this application.
- If the Beneficiary is a Trust, please include the Trust's name, date the Trust was executed, Trustee's name and a location a copy of the Trust can be found.
- **You cannot use this form to change your beneficiary(ies).** If the beneficiary(ies) you indicate below does not match our records, you will be sent a Change of Beneficiary form, 380-2005, to complete and return to our office to record your change.

Primary Beneficiary: _____
Social Security Number: _____ Phone Number: _____
Relationship to Insured: _____ Date of Birth: _____
Address: _____

Contingent Beneficiary: _____
Social Security Number: _____ Phone Number: _____
Relationship to Insured: _____ Date of Birth: _____
Address: _____



3) Reinstatement

- I am applying for the reinstatement of the policy indicated above, in accordance with the terms and conditions of the policy provisions. I agree that the reinstatement of my policy is contestable for two years in the case of fraud or misrepresentation of any material facts in the above answers.

AND

- I have enclosed payment with this completed form.

4) Statement of Insurability

(If a reinstatement or a change in the existing policy is being requested, the insured must complete this section.)

- A)** What is your Height? _____ Weight? _____
- B)** In the last three years, have you used any form of tobacco, nicotine or nicotine replacement therapy (including, but not limited to: cigarette, cigar, pipe, chewing tobacco, nicotine gum, electronic cigarettes, nicotine patch or nasal spray)?
Type: _____ Date Last Used: _____
- C)** Name of Personal Physician: _____ (if none, state so)
Address of Personal Physician: _____
Last Visit: _____ Reason Last Seen: _____
Diagnosis/Treatment: _____
- D)** In the last ten years, have you been treated or diagnosed by a member of the medical profession for diabetes, cancer, heart disease, stroke or had treatment or counseling for alcohol or other drug dependency? Yes No
If yes, please explain: _____
- E)** Are you currently taking any medications? Yes No
Medication Name & Physician Prescribing: _____
- F)** In the past five years, have you been or are you currently being treated by a licensed member of the medical profession for anxiety or depression? Yes No
If yes, provide the name and address of the treating Physician: _____
- G)** In the past five years, have you been diagnosed, taken medication or been treated by a licensed member of the medical profession for any condition, disease or disorder, other than mentioned above? Yes No
If yes, please explain: _____
- H)** In the past two years, have you piloted an aircraft or do you hold a valid pilot's license? Yes No
If yes, please explain: _____
- I)** Have you ever engaged, or do you intend within the next two years to engage in the following activities: motorized racing, scuba diving, skydiving, parachuting, hang-gliding, bungee jumping, mountain climbing, boat racing, spelunking, boxing, wrestling, ballooning? Yes No
If yes, please indicate activity: _____

5) Authorization, Disclosure and Signature

To help Sentry determine my (our) insurability:

- I (we) authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, pharmacy or pharmacy benefit manager involved in my (our) care, insurance company or reinsurance company, financial or motor vehicle department or employer, to release to Sentry, or any person or entity acting on its behalf, any personal information which is on file and relates to my (our) mental or health condition, or any other nonmedical information of me (us) or that of my (our) dependents. This includes, but is not limited to information regarding diagnosis, prognosis, and treatment for: physical, psychological, psychiatric and emotional illness; treatment of alcohol or drug abuse; communicable or venereal disease; Hepatitis A, B and C, sickle cell anemia and pharmaceutical medical information. This also includes treatment of Human Immunodeficiency Virus (HIV) infection.
- I (we) authorize the MIB Inc. to release to Sentry, or its reinsurers, any personal information which is on file and relates to me (us) or my (our) dependents.
- I (we) authorize Sentry Life Insurance Company or its reinsurers, to make a brief report of my personal health information to the MIB Inc.
- I (we) authorize Sentry to release any such data to its reinsurers, MIB, Inc. or as required by law or as provided by the Important Notice.
- These authorizations shall remain valid for use by Sentry until two years from the date below. I understand I may revoke this authorization at any time by written request to Sentry Life Insurance Company, Home Office, P.O. Box 8027, Stevens Point, WI 54481-8027. The request must be executed by the person who signs below. I also understand that revocation of my authorization will have no effect on actions Sentry or its agents have already taken in reliance on the authorization before revocation.
- The applicant, or the applicants authorized representative, may receive a photocopy of the authorization form.
- A reproduced copy will be as valid as the original.

I represent that the statements and answers in this application are true and complete to the best of my (our) knowledge and belief. I (we) certify that the Social Security Number(s) provided on this form is (are) true, correct and complete. It is agreed that:

- All statements and answers in this application will form the basis of any contract of insurance that may be issued, changed and added, and that no information about me will be considered to have been given to the company unless it is stated in the application.
- Sentry Life Insurance Company will use the data obtained by this authorization to determine eligibility for insurance. Sentry will not release any data obtained to any person or organization except to reinsurance companies or the MIB Inc., or as required by law, or as I may further authorize. Data obtained from sources other than the MIB Inc., may also be released to other persons or organizations performing business or legal services in connection with my application or claim.
- I understand my medical records and information which is Protected Health Information governed by the Health Insurance Portability and Accountability Act, once disclosed to others, may be redisclosed by the recipients and is no longer protected by that Act or the underlying privacy regulations.
- Sentry reserves the right to require a medical examination of the Proposed Insured(s) through our contracted Paramedical Companies, based on the medical questions answered within Section 4 of the application.
- Sentry reserves the right to request a Motor Vehicle Report through our contracted companies.
- Sentry reserves the right to request a Credit Report through our contracted companies.
- A copy of the application and any amendments or supplements shall be attached to and be made part of the policy, if issued.
- The proposed insured, or authorized representative of the proposed insured, must sign this authorization. I understand if I do not sign this authorization, Sentry may refuse to insure me.
- Acceptance of any policy issued on the application will constitute a ratification of corrections, additions, or changes made by Sentry and noted on an attachment to the policy, except that any change in amount, plan of insurance, age at issue, classifications or benefits will be subject to written acceptance by me.
- Only the President, a Vice-President or Secretary of Sentry can make, modify, alter or discharge contracts or waive any of Sentry's right or requirements.
- I (we) also agree that I (we) have received and read the Important Notice required by the Fair Credit Reporting Act and MIB Inc.

5) Authorization, Disclosure and Signature - Continued

A) Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for this life insurance policy? Yes No

Notice: State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

B) Do you currently own a life insurance policy issued by Sentry Life Insurance Company? Yes No

1) Do you have any existing life insurance policies, endowment contracts or annuity contracts in force with another company? Yes No

2) Is this life insurance policy applied for intended to replace, discontinue or change any existing life insurance, endowment contract or annuity contract issued by any company? Yes No

Fraud Disclosure

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

• This application has been signed by the Insured in _____ (city) _____ (state) ,
on _____ (month) _____ (day) _____ (year) .

Insured Signature (print if under age 15)

Printed Insured's Name

Spouse, if insured

Parent/Legal Guardian, if insured is under age 15

• This application has been signed by the Policy Owner in _____ (city) _____ (state) ,
on _____ (month) _____ (day) _____ (year) .

Owner, if other than Insured; if a Corporation, Partnership or Trust, indicate Officer and Title

Assignee, if any

Witness Signature

Printed Name of the Witness

Sales Producer:

- To the best of my knowledge, replacement is is not involved in this transaction.
- Each application question was asked by me of the applicant(s). All answers have been accurately recorded. I have witnessed the signing of this application by the insured/owner.

Sales Producer Signature

Sales Code

6) Term Conversion

In accordance with the Conversion provision of this policy, I (we) request that this Term Policy be converted to a new policy or policies conforming to the specifications below:

A) Plan of Insurance: _____ **Amount of Insurance:** _____

B) Automatic Premium Loan? (not available on Universal Life) Yes No

C) Partial Conversion: (choose one)

- Remaining term insurance not converted shall be discontinued.
- Remaining term insurance not converted shall be continued provided the amount is not less than the minimum allowed by the Company for that term insurance policy or benefit.

D) Tobacco Usage Questions:

In the last three years, have you used any form of tobacco, nicotine or nicotine replacement therapy (including, but not limited to: cigarette, cigar, pipe, chewing tobacco, nicotine gum, electronic cigarettes, nicotine patch or nasal spray)?

Yes No

Type: _____ Date last used: _____

If the term policy had been issued with tobacco-use rates and you are now requesting a change of that rating, please complete sections 2, 4 and 5 of this form for requesting a change in classification.

E) Premium Payable - indicate the payment option requested

- Annual Semiannual Quarterly List Bill - Sponsor # _____
- Monthly Bank Check Plan (Complete form 340-1608 only if the converted or partially converted term policy was not on a monthly bank check plan or if you have changed banks.)

F) Complete this section if you would like to continue a benefit which was on the term policy being converted.

- Waiver Benefit: Yes No
- Accidental Death Rider: Yes No
- Children's Term Rider: Yes No

- **If you are requesting the addition of the Waiver Benefit or the Accidental Death Rider, please complete sections 2, 4 and 5 of this form.**
- **If you are requesting the addition of the Children's Term Rider, please complete section 5 of this form and submit a new life application including information on each child in the Children's Term Rider section.**

Fraud Disclosure

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

G) Signatures:

This application has been signed by the insured in _____, _____ (state),
on _____ (month) _____ (day) _____ (year).

Insured Signature (print if under age 15) Insured's Printed Name

Spouse, if insured Parent/Legal Guardian, if insured is under age 15

This application has been signed by the policy owner in _____, _____ (state),
on _____ (month) _____ (day) _____ (year).

Owner, if other than Insured; if a Corporation, Partnership or Trust, indicate Officer and Title

IMPORTANT NOTICE - KEEP FOR YOUR RECORDS

Important Notice from Sentry

We believe you should know exactly what you're getting when you purchase a life insurance policy, or additional benefits, and what happens while your application(s) is/are being processed. So, we've written your policy, benefits and consumer information notices in easy-to-understand language with no legal jargon or fine print. We feel greater understanding of your rights and our obligations will improve our ability to serve you.

Information about you helps us evaluate your application.

Like you, we are concerned about your privacy. But, we must have certain information about you to fairly evaluate your life insurance application(s). We need to look at the accuracy of information on the application(s), at your life insurance needs and at your exposure to various risks in order to determine a fair price for your insurance protection. Otherwise, people with fewer risks would have to pay the same rate as people with higher risks.

We may consult various sources.

These include:

- Statements you make on the application(s);
- Results of your physical examination and/or medical studies (if required);
- Reports we received from doctors or medical facilities;
- Consumer reports;
- MIB Inc.

The consumer report may be obtained through personal interviews with your neighbors, friends, employers or others you know. It includes information regarding your character, general reputation, personal characteristics and lifestyle. If you make a written request, we will mail you a complete and accurate account of the nature and scope of any investigation we have requested within 5 days after we receive your written request. You should understand that information contained in a report prepared for us by an outside agency may be kept by the agency and disclosed to others. You may receive and inspect any such report directly from the consumer reporting agency. You may also contact the Federal Trade Commission for a written summary of consumer rights prepared pursuant to section 609(c) of the Fair Credit Reporting Act.

Information about you will be treated as confidential.

Disclosures will be made to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted, or to our reinsurers, but only upon your authorization. Disclosures will be made without your authorization only when required by statute or regulation in response to the legal process. Information for consumers about MIB Inc. may be obtained on its website at www.mib.com.

Information regarding your insurability will be treated as confidential. Sentry, or its reinsurers, may, however, make a brief report on this 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 company, MIB Inc., upon request, will supply that company with the information about you in its file.

Medical information in our files can be disclosed to you only through your attending physician.

You have access to your records.

Upon receipt of a written request from you, MIB Inc. will arrange disclosure of any information it may have in your file. Please contact MIB Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in the MIB's file, you may contact MIB Inc. and request a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB Inc. Information Office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

You may obtain a description of any personal information Sentry maintains concerning you and, if necessary, seek a correction by writing the Director of Individual Life Underwriting, Sentry Life Insurance Company, Home Office, P.O. Box 8027, Stevens Point, WI 54481-8027, or calling (800) 533-7827. You will be sent an inquiry form to be completed and returned to us.

SERFF Tracking #:

SLIN-128723895

State Tracking #:**Company Tracking #:**

340-1576

State:

Arkansas

Filing Company:

Sentry Life Insurance Company

TOI/Sub-TOI:

L08 Life - Other/L08.000 Life - Other

Product Name:

I Life Consolidation Form

Project Name/Number:

Reinstate/Conversion/Reqst for Serv/340-1576

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification		
Comments:	Attached is a completed Flesch Certification		
Attachment(s):	Flesch Cert_10-11-2012.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Application		
Comments:	The application is being submitted under the Forms tab for your review and approval.		

		Item Status:	Status Date:
Satisfied - Item:	340-1576 Combination Administrative Application, Variable		
Comments:	Attached is a variable version of the application		
Attachment(s):	340-1576_Variable_10-09-2012.pdf		

		Item Status:	Status Date:
Satisfied - Item:	340-1576 Combination Administrative Application, Watermarked for Term Conversion		
Comments:	Attached is an example of a watermarked form, which would be used if the policy owner would like to request a term conversion.		
Attachment(s):	340-1576_Watermark_10-09-2012.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability		
Comments:	Attached is a statement of variability for your convenience		
Attachment(s):	STATEMENT OF VARIABILITY_Generic_10-11-2012.pdf		

Sentry Life Insurance Company
1800 North Point Drive
P.O. Box 8020
Stevens Point, WI 54481-8020

800 533-7827
715 346-7516 Fax



I hereby certify to the best of my knowledge that the following contract, application and endorsements, which will be made part of the contract, meet the Flesch Readability score of 40 set forth by the Arkansas Department of Insurance, A.C.A. § 23-80-206

<u>Form</u>	<u>Form Number</u>	<u>Score</u>
Individual Life Insurance Request for Service, Term Conversion or Reinstatement Application	340-1576	46.6



Signature

Kenneth Erler

Name

Vice President, Sentry Life Insurance Company

Title

October 11, 2012

Date

Sentry Life Insurance Company

1800 North Point Drive
P.O. Box 8028
Stevens Point, WI 54481-8028

800-533-7827
715-346-7283 Fax



SENTRY[®]
LIFE INSURANCE
COMPANY

**INDIVIDUAL LIFE INSURANCE
REQUEST FOR SERVICE, TERM CONVERSION or REINSTATEMENT APPLICATION**

Existing Policy Number: _____

Please work with your Sentry Sales Producer to make any changes or updates to your policy. If you do not have a Sales Producer, please call 800-533-7827, press option 1 and our Home Office staff will assist you in completing these forms.

- 1. Reinstatement of a Lapsed Policy (complete sections 1, 3, 4 and 5 only)
- 2. Change to an Existing Policy (complete sections 1, 2, 4 and 5 only)
A new Life Insurance Application is REQUIRED if the following coverages are being applied for: *Spouse Benefit, Children's Benefit, Family Benefit, Other Insured Benefit, Payor Benefit or Increase in Specified Amount*
- 3. Term Conversion (complete sections 1 and 6 only)

1) Insured/Owner/Beneficiary Information

A) Complete this section with the Insured information.

Insured: _____ Date of Birth: _____
 Social Security Number: _____ Daytime Phone Number: _____
 Best Time to Call: _____ Home Phone Number: _____
 Mailing Address: _____
 Residential Address: _____
 Email Address (optional): _____

B) Complete this section only if the Insured is not the Policy Owner.

Policy Owner: _____ Date of Birth: _____
 Social Security Number: _____ Daytime Phone Number: _____
 Best Time to Call: _____ Home Phone Number: _____
 Mailing Address: _____
 Residential Address: _____
 Email Address (optional): _____

C) Complete this section with Beneficiary designations.

- For additional Beneficiaries, please attach a separate list to the end of this application.
- If the Beneficiary is a Trust, please include the Trust's name, date the Trust was executed, Trustee's name and a location a copy of the Trust can be found.
- **You cannot use this form to change your beneficiary(ies).** If the beneficiary(ies) you indicate below does not match our records, you will be sent a Change of Beneficiary form, 380-2005, to complete and return to our office to record your change.

Primary Beneficiary: _____
 Social Security Number: _____ Phone Number: _____
 Relationship to Insured: _____ Date of Birth: _____
 Address: _____

Contingent Beneficiary: _____
 Social Security Number: _____ Phone Number: _____
 Relationship to Insured: _____ Date of Birth: _____
 Address: _____



3) Reinstatement

- I am applying for the reinstatement of the policy indicated above, in accordance with the terms and conditions of the policy provisions. I agree that the reinstatement of my policy is contestable for two years in the case of fraud or misrepresentation of any material facts in the above answers.

AND

- I have enclosed payment with this completed form.

4) Statement of Insurability

(If a reinstatement or a change in the existing policy is being requested, the insured must complete this section.)

- A)** What is your Height? _____ Weight? _____
- B)** In the last three years, have you used any form of tobacco, nicotine or nicotine replacement therapy (including, but not limited to: cigarette, cigar, pipe, chewing tobacco, nicotine gum, electronic cigarettes, nicotine patch or nasal spray)?
Type: _____ Date Last Used: _____
- C)** Name of Personal Physician: _____ (if none, state so)
Address of Personal Physician: _____
Last Visit: _____ Reason Last Seen: _____
Diagnosis/Treatment: _____
- D)** In the last ten years, have you been treated or diagnosed by a member of the medical profession for diabetes, cancer, heart disease, stroke or had treatment or counseling for alcohol or other drug dependency? Yes No
If yes, please explain: _____
- E)** Are you currently taking any medications? Yes No
Medication Name & Physician Prescribing: _____
- F)** In the past five years, have you been or are you currently being treated by a licensed member of the medical profession for anxiety or depression? Yes No
If yes, provide the name and address of the treating Physician: _____
- G)** In the past five years, have you been diagnosed, taken medication or been treated by a licensed member of the medical profession for any condition, disease or disorder, other than mentioned above? Yes No
If yes, please explain: _____
- H)** In the past two years, have you piloted an aircraft or do you hold a valid pilot's license? Yes No
If yes, please explain: _____
- I)** Have you ever engaged, or do you intend within the next two years to engage in the following activities: motorized racing, scuba diving, skydiving, parachuting, hang-gliding, bungee jumping, mountain climbing, boat racing, spelunking, boxing, wrestling, ballooning? Yes No
If yes, please indicate activity: _____

5) Authorization, Disclosure and Signature

To help Sentry determine my (our) insurability:

- I (we) authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, pharmacy or pharmacy benefit manager involved in my (our) care, insurance company or reinsurance company, financial or motor vehicle department or employer, to release to Sentry, or any person or entity acting on its behalf, any personal information which is on file and relates to my (our) mental or health condition, or any other nonmedical information of me (us) or that of my (our) dependents. This includes, but is not limited to information regarding diagnosis, prognosis, and treatment for: physical, psychological, psychiatric and emotional illness; treatment of alcohol or drug abuse; communicable or venereal disease; Hepatitis A, B and C, sickle cell anemia and pharmaceutical medical information. This also includes treatment of Human Immunodeficiency Virus (HIV) infection.
- I (we) authorize the MIB Inc. to release to Sentry, or its reinsurers, any personal information which is on file and relates to me (us) or my (our) dependents.
- I (we) authorize Sentry Life Insurance Company or its reinsurers, to make a brief report of my personal health information to the MIB Inc.
- I (we) authorize Sentry to release any such data to its reinsurers, MIB, Inc. or as required by law or as provided by the Important Notice.
- These authorizations shall remain valid for use by Sentry until two years from the date below. I understand I may revoke this authorization at any time by written request to Sentry Life Insurance Company, Home Office, P.O. Box 8027, Stevens Point, WI 54481-8027. The request must be executed by the person who signs below. I also understand that revocation of my authorization will have no effect on actions Sentry or its agents have already taken in reliance on the authorization before revocation.
- The applicant, or the applicants authorized representative, may receive a photocopy of the authorization form.
- A reproduced copy will be as valid as the original.

I represent that the statements and answers in this application are true and complete to the best of my (our) knowledge and belief. I (we) certify that the Social Security Number(s) provided on this form is (are) true, correct and complete. It is agreed that:

- All statements and answers in this application will form the basis of any contract of insurance that may be issued, changed and added, and that no information about me will be considered to have been given to the company unless it is stated in the application.
- Sentry Life Insurance Company will use the data obtained by this authorization to determine eligibility for insurance. Sentry will not release any data obtained to any person or organization except to reinsurance companies or the MIB Inc., or as required by law, or as I may further authorize. Data obtained from sources other than the MIB Inc., may also be released to other persons or organizations performing business or legal services in connection with my application or claim.
- I understand my medical records and information which is Protected Health Information governed by the Health Insurance Portability and Accountability Act, once disclosed to others, may be redisclosed by the recipients and is no longer protected by that Act or the underlying privacy regulations.
- Sentry reserves the right to require a medical examination of the Proposed Insured(s) through our contracted Paramedical Companies, based on the medical questions answered within Section 4 of the application.
- Sentry reserves the right to request a Motor Vehicle Report through our contracted companies.
- Sentry reserves the right to request a Credit Report through our contracted companies.
- A copy of the application and any amendments or supplements shall be attached to and be made part of the policy, if issued.
- The proposed insured, or authorized representative of the proposed insured, must sign this authorization. I understand if I do not sign this authorization, Sentry may refuse to insure me.
- Acceptance of any policy issued on the application will constitute a ratification of corrections, additions, or changes made by Sentry and noted on an attachment to the policy, except that any change in amount, plan of insurance, age at issue, classifications or benefits will be subject to written acceptance by me.
- Only the President, a Vice-President or Secretary of Sentry can make, modify, alter or discharge contracts or waive any of Sentry's right or requirements.
- I (we) also agree that I (we) have received and read the Important Notice required by the Fair Credit Reporting Act and MIB Inc.

5) Authorization, Disclosure and Signature - Continued

A) Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for this life insurance policy? Yes No

Notice: State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

B) Do you currently own a life insurance policy issued by Sentry Life Insurance Company? Yes No

1) Do you have any existing life insurance policies, endowment contracts or annuity contracts in force with another company? Yes No

2) Is this life insurance policy applied for intended to replace, discontinue or change any existing life insurance, endowment contract or annuity contract issued by any company? Yes No

Fraud Disclosure

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

• This application has been signed by the Insured in _____ (city) _____ (state) ,
on _____ (month) _____ (day) _____ (year) .

Insured Signature (print if under age 15)

Printed Insured's Name

Spouse, if insured

Parent/Legal Guardian, if insured is under age 15

• This application has been signed by the Policy Owner in _____ (city) _____ (state) ,
on _____ (month) _____ (day) _____ (year) .

Owner, if other than Insured; if a Corporation, Partnership or Trust, indicate Officer and Title

Assignee, if any

Witness Signature

Printed Name of the Witness

Sales Producer:

- To the best of my knowledge, replacement is is not involved in this transaction.
- Each application question was asked by me of the applicant(s). All answers have been accurately recorded. I have witnessed the signing of this application by the insured/owner.

Sales Producer Signature

Sales Code

6) Term Conversion

In accordance with the Conversion provision of this policy, I (we) request that this Term Policy be converted to a new policy or policies conforming to the specifications below:

A) Plan of Insurance: _____ **Amount of Insurance:** _____

B) Automatic Premium Loan? (not available on Universal Life) Yes No

C) Partial Conversion: (choose one)

- Remaining term insurance not converted shall be discontinued.
- Remaining term insurance not converted shall be continued provided the amount is not less than the minimum allowed by the Company for that term insurance policy or benefit.

D) Tobacco Usage Questions:

In the last three years, have you used any form of tobacco, nicotine or nicotine replacement therapy (including, but not limited to: cigarette, cigar, pipe, chewing tobacco, nicotine gum, electronic cigarettes, nicotine patch or nasal spray)? Yes No

Type: _____ Date last used: _____

If the term policy had been issued with tobacco-use rates and you are now requesting a change of that rating, please complete sections 2, 4 and 5 of this form for requesting a change in classification.

E) Premium Payable - indicate the payment option requested

- Annual Semiannual Quarterly List Bill - Sponsor # _____
- Monthly Bank Check Plan (Complete form 340-1608 only if the converted or partially converted term policy was not on a monthly bank check plan or if you have changed banks.)

F) Complete this section if you would like to continue a benefit which was on the term policy being converted.

- Waiver Benefit: Yes No
- Accidental Death Rider: Yes No
- Children's Term Rider: Yes No

- If you are requesting the **addition** of the Waiver Benefit or the Accidental Death Rider, please complete sections 2, 4 and 5 of this form.
- If you are requesting the **addition** of the Children's Term Rider, please complete section 5 of this form and submit a new life application including information on each child in the Children's Term Rider section.

Fraud Disclosure

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

G) Signatures:

This application has been signed by the insured in _____, _____ (state),
on _____ (month) _____ (day) _____ (year).

Insured Signature (print if under age 15) Insured's Printed Name

Spouse, if insured Parent/Legal Guardian, if insured is under age 15

This application has been signed by the policy owner in _____, _____ (state),
on _____ (month) _____ (day) _____ (year).

Owner, if other than Insured; if a Corporation, Partnership or Trust, indicate Officer and Title

IMPORTANT NOTICE - KEEP FOR YOUR RECORDS**Important Notice from Sentry**

We believe you should know exactly what you're getting when you purchase a life insurance policy, or additional benefits, and what happens while your application(s) is/are being processed. So, we've written your policy, benefits and consumer information notices in easy-to-understand language with no legal jargon or fine print. We feel greater understanding of your rights and our obligations will improve our ability to serve you.

Information about you helps us evaluate your application.

Like you, we are concerned about your privacy. But, we must have certain information about you to fairly evaluate your life insurance application(s). We need to look at the accuracy of information on the application(s), at your life insurance needs and at your exposure to various risks in order to determine a fair price for your insurance protection. Otherwise, people with fewer risks would have to pay the same rate as people with higher risks.

We may consult various sources.

These include:

- Statements you make on the application(s);
- Results of your physical examination and/or medical studies (if required);
- Reports we received from doctors or medical facilities;
- Consumer reports;
- MIB Inc.

The consumer report may be obtained through personal interviews with your neighbors, friends, employers or others you know. It includes information regarding your character, general reputation, personal characteristics and lifestyle. If you make a written request, we will mail you a complete and accurate account of the nature and scope of any investigation we have requested within 5 days after we receive your written request. You should understand that information contained in a report prepared for us by an outside agency may be kept by the agency and disclosed to others. You may receive and inspect any such report directly from the consumer reporting agency. You may also contact the Federal Trade Commission for a written summary of consumer rights prepared pursuant to section 609(c) of the Fair Credit Reporting Act.

Information about you will be treated as confidential.

Disclosures will be made to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted, or to our reinsurers, but only upon your authorization. Disclosures will be made without your authorization only when required by statute or regulation in response to the legal process. Information for consumers about MIB Inc. may be obtained on its website at www.mib.com.

Information regarding your insurability will be treated as confidential. Sentry, or its reinsurers, may, however, make a brief report on this 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 company, MIB Inc., upon request, will supply that company with the information about you in its file.

Medical information in our files can be disclosed to you only through your attending physician.

You have access to your records.

Upon receipt of a written request from you, MIB Inc. will arrange disclosure of any information it may have in your file. Please contact MIB Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in the MIB's file, you may contact MIB Inc. and request a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB Inc. Information Office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

You may obtain a description of any personal information Sentry maintains concerning you and, if necessary, seek a correction by writing the Director of Individual Life Underwriting, Sentry Life Insurance Company, Home Office, P.O. Box 8027, Stevens Point, WI 54481-8027, or calling (800) 533-7827. You will be sent an inquiry form to be completed and returned to us.



INDIVIDUAL LIFE INSURANCE REQUEST FOR SERVICE, TERM CONVERSION or REINSTATEMENT APPLICATION

Existing Policy Number: _____

Please work with your Sentry Sales Producer to make any changes or updates to your policy. If you do not have a Sales Producer, please call 800-533-7827, press option 1 and our Home Office staff will assist you in completing these forms.

1. Reinstatement of a Lapsed Policy (**complete sections 1, 3, 4 and 5 only**)
2. Change to an Existing Policy (**complete sections 1, 2, 4 and 5 only**)
A new Life Insurance Application is REQUIRED if the following coverages are being applied for: *Spouse Benefit, Children's Benefit, Family Benefit, Other Insured Benefit, Payor Benefit or Increase in Specified Amount*
3. Term Conversion (**complete sections 1 and 6 only**)

1) Insured/Owner/Beneficiary Information

A) Complete this section with the Insured information.

Insured: _____ Date of Birth: _____
Social Security Number: _____ Daytime Phone Number: _____
Best Time to Call: _____ Home Phone Number: _____
Mailing Address: _____
Residential Address: _____
Email Address (optional): _____

B) Complete this section only if the Insured is not the Policy Owner.

Policy Owner: _____ Date of Birth: _____
Social Security Number: _____ Daytime Phone Number: _____
Best Time to Call: _____ Home Phone Number: _____
Mailing Address: _____
Residential Address: _____
Email Address (optional): _____

C) Complete this section with Beneficiary designations.

- For additional Beneficiaries, please attach a separate list to the end of this application.
- If the Beneficiary is a Trust, please include the Trust's name, date the Trust was executed, Trustee's name and a location a copy of the Trust can be found.
- You cannot use this form to change your beneficiary(ies).** If the beneficiary(ies) you indicate below does not match our records, you will be sent a Change of Beneficiary form, 380-2005, to complete and return to our office to record your change.

Primary Beneficiary: _____
Social Security Number: _____ Phone Number: _____
Relationship to Insured: _____ Date of Birth: _____
Address: _____

Contingent Beneficiary: _____
Social Security Number: _____ Phone Number: _____
Relationship to Insured: _____ Date of Birth: _____
Address: _____



2) Change to an Existing Policy

A) ADD the following benefit to this policy (no Statement of Insurability required):

Automatic Premium Loan

B) Make the following CHANGE(S) to this policy (no Statement of Insurability required):

Change Address on Record to: _____

Change Insured's Name to: _____
(Include a copy of the legal documentation regarding the name change)

Change Premium Payment Method to:

Annual Semi-Annual Quarterly List Bill - Employer # _____

Monthly Bank Check Plan (Complete form 340-1603 if the policy was not on a monthly bank check plan or if you have changed banks.)

NOT APPLICABLE

Place this Policy on Reduced Paid-Up Insurance

Place this Policy on Extended Term Insurance (Not Available on Special Class Policies)

Reduce the Specified Amount from: \$ _____ to \$ _____

Change from Death Benefit Option _____ to Death Benefit Option _____
(A/1 or B/2) (A/1 or B/2)

resulting in a Specified Amount of \$ _____

Remove _____ from this policy effective _____

Change _____

Complete the Statement of Insurability on Section 4 for the following ADDITIONS/CHANGES to this policy:

C) ADD the following benefit to this policy (Completed Statement of Insurability required):

Waiver of Premium Benefit

Accidental Death Benefit \$ _____

Guaranteed Insurability Benefit \$ _____

NOT APPLICABLE

D) Make the following CHANGE(S) to this policy (Completed Statement of Insurability required):

Change Smoker or Tobacco User Status to: _____

Reduce Rating of: _____

Reason: _____

3) Reinstatement

I am applying for the reinstatement of the policy indicated above, in accordance with the terms and conditions of the policy provisions. I agree that the reinstatement of my policy is contestable for two years in the case of fraud or misrepresentation of any material fact in the above answers.

AND

NOT APPLICABLE

I have enclosed payment with this completed form.

4) Statement of Insurability

(If a reinstatement or a change in the existing policy is being requested, the insured must complete this section.)

A) What is your Height? _____ Weight? _____

B) In the last three years, have you used any form of tobacco, nicotine or nicotine replacement therapy (including, but not limited to: cigarette, cigar, pipe, chewing tobacco, nicotine gum, electronic cigarettes, nicotine patch or nasal spray)?

Type: _____ Date Last Used: _____

C) Name of Personal Physician: _____ (if none, state so)

Address of Personal Physician: _____

Last Visit: _____ Reason Last Seen: _____

Diagnosis/Treatment: _____

D) In the last ten years, have you been treated or diagnosed by a member of the medical profession for diabetes, cancer, heart disease, stroke or had treatment or counseling for alcohol or other drug dependency? Yes No

If yes, please explain: _____

E) Are you currently taking any medications? Yes No
Medication Name & Physician Prescribing: _____

NOT APPLICABLE

F) In the past five years, have you been or are you currently being treated by a licensed member of the medical profession for anxiety or depression? Yes No

If yes, provide the name and address of the treating Physician: _____

G) In the past five years, have you been diagnosed, taken medication or been treated by a licensed member of the medical profession for any condition, disease or disorder, other than mentioned above? Yes No

If yes, please explain: _____

H) In the past two years, have you piloted an aircraft or do you hold a valid pilot's license? Yes No

If yes, please explain: _____

I) Have you ever engaged, or do you intend within the next two years to engage in the following activities: motorized racing, scuba diving, skydiving, parachuting, hang-gliding, bungee jumping, mountain climbing, boat racing, spelunking, boxing, wrestling, ballooning? Yes No

If yes, please indicate activity: _____

5) Authorization, Disclosure and Signature

To help Sentry determine my (our) insurability:

- I (we) authorize any licensed physician, medical practitioner, hospital, clinic or other medically related facility, pharmacy or pharmacy benefit manager involved in my (our) care, insurance company or reinsurance company, financial or motor vehicle department or employer, to release to Sentry, or any person or entity acting on its behalf, any personal information which is on file and relates to my (our) mental or health condition, or any other nonmedical information of me (us) or that of my (our) dependents. This includes, but is not limited to information regarding diagnosis, prognosis, and treatment for: physical, psychological, psychiatric and emotional illness; treatment of alcohol or drug abuse; communicable or venereal disease; Hepatitis A, B and C, sickle cell anemia and pharmaceutical medical information. This also includes treatment of Human Immunodeficiency Virus (HIV) infection.
- I (we) authorize the MIB Inc. to release to Sentry, or its reinsurers, any personal information which is on file and relates to me (us) or my (our) dependents.
- I (we) authorize Sentry Life Insurance Company or its reinsurers, to make a brief report of my personal health information to the MIB Inc.
- I (we) authorize Sentry to release any such data to its reinsurers, MIB, Inc. or as required by law or as provided by the Important Notice.
- These authorizations shall remain valid for use by Sentry until two years from the date below. I understand I may revoke this authorization at any time by written request to Sentry Life Insurance Company, Home Office, P.O. Box 8027, Stevens Point, WI 54481-8027. The request must be executed by the person who signs below. I also understand that revocation of my authorization will have no effect on actions Sentry or its agents have already taken in reliance on the authorization before revocation.
- The applicant or the applicants authorize the representative, may receive a photocopy of the authorization form.
- A reproduced copy will be as valid as the original.

NOT APPLICABLE

I represent that the statements and answers in this application are true and complete to the best of my (our) knowledge and belief. I (we) certify that the Social Security Number(s) provided on this form is (are) true, correct and complete. It is agreed that:

- All statements and answers in this application will form the basis of any contract of insurance that may be issued, changed and added, and that no information about me will be considered to have been given to the company unless it is stated in the application.
- Sentry Life Insurance Company will use the data obtained by this authorization to determine eligibility for insurance. Sentry will not release any data obtained to any person or organization except to reinsurance companies or the MIB Inc., or as required by law, or as I may further authorize. Data obtained from sources other than the MIB Inc., may also be released to other persons or organizations performing business or legal services in connection with my application or claim.
- I understand my medical records and information which is Protected Health Information governed by the Health Insurance Portability and Accountability Act, once disclosed to others, may be redisclosed by the recipients and is no longer protected by that Act or the underlying privacy regulations.
- Sentry reserves the right to require a medical examination of the Proposed Insured(s) through our contracted Paramedical Companies, based on the medical questions answered within Section 4 of the application.
- Sentry reserves the right to request a Motor Vehicle Report through our contracted companies.
- Sentry reserves the right to request a Credit Report through our contracted companies.
- A copy of the application and any amendments or supplements shall be attached to and be made part of the policy, if issued.
- The proposed insured, or authorized representative of the proposed insured, must sign this authorization. I understand if I do not sign this authorization, Sentry may refuse to insure me.
- Acceptance of any policy issued on the application will constitute a ratification of corrections, additions, or changes made by Sentry and noted on an attachment to the policy, except that any change in amount, plan of insurance, age at issue, classifications or benefits will be subject to written acceptance by me.
- Only the President, a Vice-President or Secretary of Sentry can make, modify, alter or discharge contracts or waive any of Sentry's right or requirements.
- I (we) also agree that I (we) have received and read the Important Notice required by the Fair Credit Reporting Act and MIB Inc.

5) Authorization, Disclosure and Signature - Continued

A) Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for this life insurance policy? Yes No

Notice: State insurance law may prohibit the owner of a life insurance policy from entering into any agreement to sell, transfer or assign a life insurance policy prior to the date the policy was issued, or within a period of time specified by state law after the date the policy was issued. You should consult with legal advisors if you have any questions about these matters.

B) Do you currently own a life insurance policy issued by Sentry Life Insurance Company? Yes No

1) Do you have any existing life insurance policies, endowment contracts or annuity contracts in force with another company? Yes No

2) Is this life insurance policy applied for intended to replace, discontinue or change any existing life insurance, endowment contract or annuity contract issued by any company? Yes No

Fraud Disclosure

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

NOT APPLICABLE

• This application has been signed by the Insured in _____ (city), _____ (state),
on _____ (month) _____ (day) _____ (year).

Insured Signature (print if under age 15) Printed Insured's Name

Spouse, if insured Parent/Legal Guardian, if insured is under age 15

• This application has been signed by the Policy Owner in _____ (city), _____ (state),
on _____ (month) _____ (day) _____ (year).

Owner, if other than Insured; if a Corporation, Partnership or Trust, indicate Officer and Title

Assignee, if any

Witness Signature Printed Name of the Witness

Sales Producer:

- To the best of my knowledge, replacement is is not involved in this transaction.
- Each application question was asked by me of the applicant(s). All answers have been accurately recorded. I have witnessed the signing of this application by the insured/owner.

Sales Producer Signature Sales Code

6) Term Conversion

In accordance with the Conversion provision of this policy, I (we) request that this Term Policy be converted to a new policy or policies conforming to the specifications below:

A) Plan of Insurance: _____ **Amount of Insurance:** _____

B) Automatic Premium Loan? (not available on Universal Life) Yes No

C) Partial Conversion: (choose one)

- Remaining term insurance not converted shall be discontinued.
- Remaining term insurance not converted shall be continued provided the amount is not less than the minimum allowed by the Company for that term insurance policy or benefit.

D) Tobacco Usage Questions:

In the last three years, have you used any form of tobacco, nicotine or nicotine replacement therapy (including, but not limited to: cigarette, cigar, pipe, chewing tobacco, nicotine gum, electronic cigarettes, nicotine patch or nasal spray)? Yes No

Type: _____ Date last used: _____

If the term policy had been issued with tobacco-use rates and you are now requesting a change of that rating, please complete sections 2, 4 and 5 of this form for requesting a change in classification.

E) Premium Payable - indicate the payment option requested

- Annual Semiannual Quarterly List Bill - Sponsor # _____
- Monthly Bank Check Plan (Complete form 340-1608 only if the converted or partially converted term policy was not on a monthly bank check plan or if you have changed banks.)

F) Complete this section if you would like to continue a benefit which was on the term policy being converted.

- Waiver Benefit: Yes No
- Accidental Death Rider: Yes No
- Children's Term Rider: Yes No

- **If you are requesting the addition of the Waiver Benefit or the Accidental Death Rider, please complete sections 2, 4 and 5 of this form.**
- **If you are requesting the addition of the Children's Term Rider, please complete section 5 of this form and submit a new life application including information on each child in the Children's Term Rider section.**

Fraud Disclosure

Any person who knowingly presents a false statement in an application for insurance may be guilty of a criminal offense and subject to penalties under state law.

G) Signatures:

This application has been signed by the insured in _____, _____ (state),
 on _____ (month) _____ (day) _____ (year).

 Insured Signature (print if under age 15) Insured's Printed Name

 Spouse, if insured Parent/Legal Guardian, if insured is under age 15

This application has been signed by the policy owner in _____, _____ (state),
 on _____ (month) _____ (day) _____ (year).

 Owner, if other than Insured; if a Corporation, Partnership or Trust, indicate Officer and Title

IMPORTANT NOTICE - KEEP FOR YOUR RECORDS

Important Notice from Sentry

We believe you should know exactly what you're getting when you purchase a life insurance policy, or additional benefits, and what happens while your application(s) is/are being processed. So, we've written your policy, benefits and consumer information notices in easy-to-understand language with no legal jargon or fine print. We feel greater understanding of your rights and our obligations will improve our ability to serve you.

Information about you helps us evaluate your application.

Like you, we are concerned about your privacy. But, we must have certain information about you to fairly evaluate your life insurance application(s). We need to look at the accuracy of information on the application(s), at your life insurance needs and at your exposure to various risks in order to determine a fair price for your insurance protection. Otherwise, people with fewer risks would have to pay the same rate as people with higher risks.

We may consult various sources.

These include:

- Statements you make on the application(s);
- Results of your physical examination and/or medical studies (if required);
- Reports we received from doctors or medical facilities;
- Consumer reports;
- MIB Inc.

The consumer report may be obtained through personal interviews with your neighbors, friends, employers or others you know. It includes information regarding your character, general reputation, personal characteristics and lifestyle. If you make a written request, we will mail you a complete and accurate account of the nature and scope of any investigation we have requested within 5 days after we receive your written request. You should understand that information contained in a report prepared for us by an outside agency may be kept by the agency and disclosed to others. You may receive and inspect any such report directly from the consumer reporting agency. You may also contact the Federal Trade Commission for a written summary of consumer rights prepared pursuant to section 609(c) of the Fair Credit Reporting Act.

Information about you will be treated as confidential.

Disclosures will be made to other insurance companies to whom you apply for life or health insurance, or to whom a claim for benefits may be submitted, or to our reinsurers, but only upon your authorization. Disclosures will be made without your authorization only when required by statute or regulation in response to the legal process. Information for consumers about MIB Inc. may be obtained on its website at www.mib.com.

Information regarding your insurability will be treated as confidential. Sentry, or its reinsurers, may, however, make a brief report on this 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 company, MIB Inc., upon request, will supply that company with the information about you in its file.

Medical information in our files can be disclosed to you only through your attending physician.

You have access to your records.

Upon receipt of a written request from you, MIB Inc. will arrange disclosure of any information it may have in your file. Please contact MIB Inc. at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in the MIB's file, you may contact MIB Inc. and request a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the MIB Inc. Information Office is 50 Braintree Hill Park, Suite 400, Braintree, MA 02184-8734.

You may obtain a description of any personal information Sentry maintains concerning you and, if necessary, seek a correction by writing the Director of Individual Life Underwriting, Sentry Life Insurance Company, Home Office, P.O. Box 8027, Stevens Point, WI 54481-8027, or calling (800) 533-7827. You will be sent an inquiry form to be completed and returned to us.

STATEMENT OF VARIABILITY – all variable language is in brackets.

340-1576 Individual Life Insurance Request for Service, Term Conversion or Reinstatement Application

This is a combination form to be used for requests for service, term conversions or reinstatement applications. All seven pages will print when this form is used, however, in an effort to make the form as convenient as possible for the policy owner, sections of the form which are not applicable to the specific request will be watermarked as "NOT APPLICABLE".

For a Term Conversion, only sections 1) Insured/Owner/Beneficiary Information and 6) Term Conversion need to be completed; therefore, sections 2) Change to an Existing Policy; 3) Reinstatement; 4) Statement of Insurability and 5) Authorization, Disclosure and Signature will be watermarked as "NOT APPLICABLE". See Supporting Documentation an example of the Term Conversion.

For a Reinstatement of a Lapsed Policy, only sections 1) Insured/Owner/Beneficiary Information; 3) Reinstatement; 4) Statement of Insurability and 5) Authorization, Disclosure and Signature need to be completed; therefore, sections 2) Change to an Existing Policy and 6) Term Conversion will be watermarked as "NOT APPLICABLE"

For a Change to an Existing Policy, only sections 1) Insured/Owner/Beneficiary Information; 2) Change to an Existing Policy; 4) Statement of Insurability and 5) Authorization, Disclosure and Signature need to be completed; therefore, sections 3) Reinstatement and 6) Term Conversion will be watermarked as "NOT APPLICABLE". 6 Sentry Life Insurance Company of New York Memorandum of Variable Material

If the Insured/Owner has multiple changes to complete, the entire form will be provided with no watermarks.

The Insured/Owner/Beneficiary Information, Changes to an Existing Policy, Reinstatement information, Statement of Insurability, signatures of the Insured, Spouse, Parent/Legal Guardian, Owner, Assignee, Witness and Sales Producer are specific to each policy.. The Sales Code is specific to the Sales Producer.

Page 1

- The Company's address, office location and phone number are bracketed for administrative purposes.
- The Change of Beneficiary form number is bracketed in the event of a form number change.
- The barcode will be policy specific

Page 2

- The Monthly Bank Check Plan form number is bracketed in the event of a form number change.

Page 4

- The Company's address and office location are bracketed for administrative purposes.

Page 6

- The Monthly Bank Check Plan form number is bracketed in the event of a form number change

Page 7

- The web site, address and phone number for the Medical Information Bureau (MIB) is bracketed in the event of change
- The Company's address, office location, phone number and contact person are bracketed for administrative purposes.