

SERFF Tracking Number: SLIN-128456905 State: Arkansas
Filing Company: Sentry Life Insurance Company State Tracking Number:
Company Tracking Number: 340-474
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Individual Life Insurance Application
Project Name/Number: Individual Life Insurance Application/340-474

Filing at a Glance

Company: Sentry Life Insurance Company

Product Name: Individual Life Insurance
Application

TOI: L08 Life - Other

Sub-TOI: L08.000 Life - Other

Filing Type: Form

SERFF Tr Num: SLIN-128456905 State: Arkansas

SERFF Status: Closed-Approved-
Closed State Tr Num:

Co Tr Num: 340-474

Authors: Melissa Barden, Mary
Rosicky

Date Submitted: 06/08/2012

State Status: Approved-Closed

Reviewer(s): Linda Bird

Disposition Date: 06/14/2012

Disposition Status: Approved-
Closed

Implementation Date:

Implementation Date Requested: On Approval

State Filing Description:

General Information

Project Name: Individual Life Insurance Application

Project Number: 340-474

Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending

Date Approved in Domicile:

Domicile Status Comments: The Individual Life Insurance Application was filed through the Interstate Insurance Product Regulation Commission and approved on May 9, 2012. Our domicile state of Wisconsin is part of the Compact.

Explanation for Combination/Other:

Submission Type: New Submission

Overall Rate Impact:

Market Type: Individual

Individual Market Type:

Filing Status Changed: 06/14/2012

State Status Changed: 06/14/2012

Created By: Mary Rosicky

Corresponding Filing Tracking Number:

Deemer Date:

Submitted By: Mary Rosicky

Filing Description:

SENTRY LIFE INSURANCE COMPANY

NAIC #169-68810

340-474 Individual Life Insurance Application

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340-1606 Individual Life Insurance Application – Amendment of Application
340-1607 Receipt-Temporary Life Insurance Agreement
340-1608 Bank Check Payment Authorization
340-1609 Important Notice, Keep For Your Records
340-1610 Authorization For Individual Life Insurance Application

The above referenced new forms are submitted for your review and approval. These forms replace existing Individual Life application forms 340-249S(SP) and 340-249(SP) that were previously filed and approved on December 18, 1998.

To the best of our knowledge and belief, the forms submitted are in compliance. The Individual Life Application, Individual Life Application – Amendment of Application, Receipt-Temporary Life Insurance Agreement, Bank Check Payment Authorization, Important Notice, Keep For Your Records and Authorization for Individual Life Insurance are for new individual life insurance business only. The Individual Life Application will be a telephonic application.

The following explains the workflow process in regards to completing our Individual Life Insurance application and the products the application will be used with.

Our product types include a level benefit term life insurance policy to age 95 and a whole life insurance policy paid up at age 100. Our company marketing names and form numbers are:

- Patriot Term III - Level Premium Term Life Insurance Policy To Age 95 and Patriot Term III – Simplified Issue Level Benefit Term Life Insurance Policy To Age 95, Form 380-2306 was previously filed and approved on November 13, 2009. The rates for Patriot Term III – Simplified Issue Level Benefit Term Life Insurance Policy to Age 95 were filed and approved on December 10, 2009 and August 9, 2010.
- Traditional Whole Life III – Whole Life Insurance Paid-Up At Age 100, Form 380-1610 was previously filed and approved on April 6, 2005.
- Form 340-249A-2, Bank Check Payment Authorization was previously filed and approved on January 13, 2009 and will be replaced by form 340-1608 (Page 1 of 3);
- Form 340-249A-2), Receipt – Temporary Life Insurance Agreement was previously filed and approved on January 13, 2009 and will be replaced by form 340-1607 (Page 2 of 3); and
- Form 340-249A-2, Important Notice, Keep for Your Records was previously filed and approved on January 13, 2009 and will be replaced by form 340-1609 (Page 3 of 3).

Sentry will be creating a new web application that our licensed Sales Producers will use to quote a life product. This new quoting facility will produce PDF images of the proposal document that reflects the insureds information that the Sales Producer entered. The proposal document will display the quoted premium for the selected life insurance product.

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<i>Filing Company:</i>	<i>Sentry Life Insurance Company</i>	<i>State Tracking Number:</i>	
<i>Company Tracking Number:</i>	<i>340-474</i>		
<i>TOI:</i>	<i>L08 Life - Other</i>	<i>Sub-TOI:</i>	<i>L08.000 Life - Other</i>
<i>Product Name:</i>	<i>Individual Life Insurance Application</i>		
<i>Project Name/Number:</i>	<i>Individual Life Insurance Application/340-474</i>		

When the Proposed Insured agrees to purchase the proposed policy as shown in the Life Insurance Proposal Summary the Sales Producer will print off the supplemental documentation from the quote that the Proposed Insured will need to sign, with a wet signature.

The following is a list of possible supplemental forms:

- Form 340-418, Important Notice - Replacement of Life Insurance or Annuities;
- Form 340-539, U.S. Military Personnel Life Insurance Disclosure;
- Form 340-1004, Notice of Intent to Insure and Consent by Proposed Insured; and
- Form 340-351, Agent's Replacement Report.

The applicable forms will print out according to how the Proposed Insured answered specific questions in the quote to trigger the proper documents. The Sales Producer will collect the wet signatures on the appropriate forms and scan the documents to Sentry Life Insurance Company (these forms have a bar code on the bottom). The documents will be picked up by an automatic process to be scanned into our Underwriting system and attached to the appropriate Proposed Insured's file and stored in a database to be viewed as a PDF at a later date. The forms have been attached under Supporting Documentation for your convenience.

The Sales Producer will contact our External Call Center to have the Proposed Insured complete Part 1 (the application) and Part 2 (the medical information) of the Individual Life Insurance Application over the phone. The External Call Center will validate with the Sales Producer that the correct proposal has been forwarded to them. The External Call Center will have the ability to retrieve the quote by entering the quote number from the Sales Producer in order to start the application process. The data that will transfer will be the policy number, creation date/time, Proposed Insured's name, product applied for/face amount, Proposed Insured's address, date-of-birth, payment mode, child rider units, automatic premium loan and rider choices; children benefit; waiver of premium, guaranteed insurability and accelerated death benefit. The rider information transferred will be specific to each Proposed Insured. If the Sales Producer confirms that the information is correct, the External Call Center will complete the telephonic application. The External Call Center will also verify the Sales Producer's information (producer ID, name, address, phone number) and if there are any changes to the quote before they talk with the Proposed Insured. The External Call Center will capture the Sales Producer's voice signature for the application. This is done by reading off a specific voice signature statement and by the Sales Producer agreeing by stating their name and current date. The Sales Producer will do a warm transfer (hands the phone over) to the Proposed Insured. The External Call Center will verify the identity of the Proposed Insured by asking for the spelling of their last name, date of birth and address.

The Proposed Insured will be asked up front by the External Call Center if they agree to a voice signature. If the Proposed Insured agrees to the voice signature, they continue on and answer all questions within the application. If the Proposed Insured opts out of the voice signature, the application will still be completed over the phone, but e-mailed to

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the Sales Producer (on a secured site) to deliver to the insured for a wet signature. The application questions are triggered based on how a question is answered, so if the Proposed Insured answers "YES" other drop down questions will become available for the External Call Center person to ask and record the Proposed Insured's answer. The questions that open up additional scripts based on a "YES" answer will appear on the "Comments section" of the application.

The Life Insurance Additional Supplement – Additional Beneficiaries document will only print with the application if the Proposed Insured has more than four beneficiaries to list on the life application. At the end of the application the voice signature will be captured. If a customer needs a medical exam to be completed, or blood drawn the exam is scheduled over the phone with the Proposed Insured. The external call center has real time access to medical facilities appointment calendars and will schedule the appointments. The following forms will be generated for the medical examiner to have the Proposed Insured sign during the exam:

- Form 340-475, Medical Examiner's Report; and
- Form 340-79, Notice and Consent Form for AIDS Virus (HIV) Testing.

The complete conversation will be recorded and stored for the life of the policy. The application data will be sent over a secured site to Sentry. The application data will create a PDF that will be the application; form 340-474. The conversation, voice signature and application data will be locked down so no modifications can be made to the original copies. Any changes to the original information will be documented through the Individual Life Insurance – Amendment of Application; form 340-1606 and attached to the policy with the original application, form 340-474. The Individual Life Insurance – Amendment of Application will reflect corrections or updates to the information initially submitted on the Individual Life Insurance Application.

Sentry's Underwriters will review the application and all applicable supporting documentation to determine insurability of the Proposed Insured. If the application is approved, a copy of the application will be issued with a Good Health Statement, form 340-171 AR; see Supporting Documentation forms, which is placed on top of the policy and sent to the Sales Producer to discuss with the Proposed Insured, prior to the Individual Life policy delivery. The Proposed Insured will review their Individual Life Application (a bar code with a signature will appear next to the signature if the customer voice signed the application) prior to the policy delivery. The Proposed Insured will be asked to sign the Good Health Statement acknowledging that there has been no change to their health since the application was taken and make a premium payment if none was previously collected.

Once the Good Health Statement and premium payment are received at Sentry's Home Office, the policy will be activated.

Variable information for all forms is indicated by brackets. Any change or modification to variable information will be administered in accordance with state law including any requirements for prior approval of a change or modification.

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Variables will not be adjusted to be less favorable than the state allows. A Statement of Variability is included under Supporting Documentation.

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

We respectfully request your approval.

Mary Rosicky
Compliance/Development Specialist
Sentry Life Insurance Company
mary.rosicky@sentry.com
715-346-6499

State Narrative:

Company and Contact

Filing Contact Information

Mary Rosicky , Compliance Specialist Mary.Rosicky@sentry.com
1800 North Point Drive 715-346-6499 [Phone] 6499 [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 company
Stevens Point, WI 54481 Group Name: Sentry Insurance State ID Number:
Group
(715) 346-6000 ext. [Phone] FEIN Number: 39-6040276

Filing Fees

Fee Required? Yes
Fee Amount: \$300.00
Retaliatory? No
Fee Explanation: 1 application and 5 supplemental application forms; 6 X \$50.00 per form = \$300.00.
Per Company: No

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COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Sentry Life Insurance Company	\$300.00	06/08/2012	59922962

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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Linda Bird	06/14/2012	06/14/2012

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Disposition

Disposition Date: 06/14/2012

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification		Yes
Supporting Document	Application		Yes
Supporting Document	340-539 US Military Personnel Life Insurance Disclosure and Acknowledgement		Yes
Supporting Document	340-1004 Notice of Intent to Insure and Consent by Proposed Insured		Yes
Supporting Document	340-475 Medical Examiner's Report		Yes
Supporting Document	340-171 AR Good Health Statement		Yes
Supporting Document	340-418 Important Notice - Replacement of Life Insurance or Annuities		Yes
Supporting Document	Statement of Variability and Life Application Data Elements		Yes
Supporting Document	340-351 Agent's Replacement Report		Yes
Supporting Document	340-79 Notice and Consent Form For AIDS Virus (HIV) Testing		Yes
Form	Individual Life Insurance Application		Yes
Form	Life Application - Amendment of Application		Yes
Form	Receipt-Temporary Life Insurance Agreement		Yes
Form	Bank Check Payment Authorization		Yes
Form	Important Notice, Keep For Your Records		Yes
Form	Authorization For Individual Life Insurance Application		Yes

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Form Schedule

Lead Form Number: 340-474

Schedule Item Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
	340-474	Application/ Enrollment Form	Individual Life Insurance Application	Initial		58.800	340-474 Individual Life Application (MIB).pdf
	340-1606	Application/ Enrollment Form	Life Application - Amendment of Application	Initial		55.700	340-1606 Individual Life Insurance App - Amendment of Application.pdf
	340-1607	Application/ Enrollment Form	Receipt-Temporary Life Insurance Agreement	Initial		50.500	340-1607 Receipt Temporary Life Insurance Agreement.pdf
	340-1608	Application/ Enrollment Form	Bank Check Payment Authorization	Initial		52.100	340-1608 Bank Check Payment Authorization.pdf
	340-1609	Application/ Enrollment Form	Important Notice, Keep For Your Records	Initial		50.200	340-1609 Important Notice, Keep For Your Records.pdf
	340-1610	Application/ Enrollment Form	Authorization For Individual Life Insurance Application	Initial		50.700	340-1610 Authorization for Ind Life Ins

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TOI: L08 Life - Other *Sub-TOI:* L08.000 Life - Other
Product Name: Individual Life Insurance Application
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Application.pdf
f

SENTRY LIFE INSURANCE COMPANY

**1800 NORTH POINT DRIVE
STEVENS POINT, WI 54481**



**SENTRY®
LIFE INSURANCE
COMPANY**

**Part 1
Individual Life Insurance Application**

Policy Number: **67-2294572**

Creation Date/Time: **01/27/2012 11:24 a.m.**

1. Proposed Insured's (Legal First Name, Middle Initial, Last Name) John C Doe		2. Product Applied For/Face Amount Level Benefit Term Life Insurance to age 95 30 yr level Premium/\$50,000	
3. Date of Birth: 01/27/77 Age: 35	4. State/Foreign Country of Birth: AR USA	5. Marital Status: Single	
6. Citizenship: Are you a U.S. Citizen? <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Country of Citizenship: []		If No, date of arrival in U.S. []	
7. Gender: <input checked="" type="checkbox"/> Male <input type="checkbox"/> Female	8. Primary Telephone Number: Home 715-669-4844	9. E-mail Address: jd@aol.com	10. Social Security Number: 123-22-0000
11. Street Address 1 123 State Street	City Anytown	State AR	ZIP Code 54476
12. Owner (Complete only if different than the Proposed Insured) Indicate type of Ownership: <input type="checkbox"/> Individual <input type="checkbox"/> Business <input type="checkbox"/> Trust Relationship: [] Social Security Number (TIN): [] Name of Trust: [] Date of Trustee: [] Location of Trust: [] Trustee Name: []			
Policy Owner (First Name - Middle Initial - Last Name) []			
Street Address 1 [] City State ZIP Code Street Address 2 []			
13. Payor (Complete only if different than the Proposed Insured) Indicate type of Payor: <input type="checkbox"/> Individual <input type="checkbox"/> Business <input type="checkbox"/> Trust Relationship: []			
Premium Payor (First Name - Middle Initial - Last Name) []			
Street Address 1 [] City State ZIP Code Street Address 2 []			
14. Payment Mode: <input checked="" type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Quarterly <input type="checkbox"/> Monthly (PAC)			
15. Riders: Child Rider: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Units: 1.5 Age: 20 Waiver of Premium: <input checked="" type="checkbox"/> Yes <input type="checkbox"/> No Automatic Premium Loan: <input type="checkbox"/> Yes <input type="checkbox"/> No [N/A for Product Type] Accidental Death Benefit \$ [] Guaranteed Insurability \$ []			
	Legal Child(rens) Name(s)	Date of Birth	Social Security Number
A	Paul B Doe	06-04-02	123-66-1111
B	Jane R Doe	09-12-05	999-99-9999
C			
D			

SENTRY LIFE INSURANCE COMPANY
1800 NORTH POINT DRIVE
STEVENS POINT, WI 54481



Policy Number: **67-2294572**

16a. Beneficiary *irrevocable Yes No **Primary** **Contingent** * default is "No" if box is not checked
 (If multiple beneficiaries are designated, benefits will be equally divided to all beneficiaries unless otherwise indicated.) **Additional Beneficiaries Supplement attached**

First Name: Paul	If other than individual, give full name
Middle Name: B	
Last Name: Doe	Date of Birth: 06-04-02
Name of Trustee: []	SSN # / TIN #: 123-66-1111
Date of Trust Agreement: []	Relation to Proposed Insured: Son
	% Benefit: 100

16b. Additional Beneficiary *irrevocable Yes No **Primary** **Contingent** * default is "No" if box is not checked

First Name: []	If other than individual, give full name
Middle Name: []	
Last Name: []	Date of Birth (mm/dd/yyyy): []
Name of Trustee: []	SSN # / TIN #: []
Date of Trust Agreement: []	Relation to Proposed Insured: []
	% Benefit: []

16c. Additional Beneficiary *irrevocable Yes No **Primary** **Contingent** * default is "No" if box is not checked

First Name: []	If other than individual, give full name
Middle Name: []	
Last Name: []	Date of Birth (mm/dd/yyyy): []
Name of Trustee: []	SSN # / TIN #: []
Date of Trust Agreement: []	Relation to Proposed Insured: []
	% Benefit: []

16d. Additional Beneficiary *irrevocable Yes No **Primary** **Contingent** * default is "No" if box is not checked

First Name: []	If other than individual, give full name
Middle Name: []	
Last Name: []	Date of Birth (mm/dd/yyyy): []
Name of Trustee: []	SSN # / TIN #: []
Date of Trust Agreement: []	Relation to Proposed Insured: []
	% Benefit: []

SENTRY LIFE INSURANCE COMPANY

1800 NORTH POINT DRIVE
STEVENS POINT, WI 54481



Policy Number: 67-2294572

If applicable, additional details for question responses are provided in the COMMENTS section.

17. Indicate the purpose for purchasing this life insurance coverage. Personal Buy/Sell Key Person
 Other

a. Will this policy be collaterally assigned? If Yes, name of the lender: Yes No

Name of Partners	% of Ownership

18. a. Do you have life insurance and/or annuities in force: Yes No

b. Will this insurance/annuity replace or change insurance with this company or any other company?
 Yes No

This would include insurance that is currently pending but bound by a temporary insurance agreement or conditional receipt.

(If YES, please list all details below and indicate if the coverage you are applying for will replace any of these.)

Company Name	Policy Type	Business or Personal	Policy Number	Effective Date	Amount	Replacing?
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

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

Notice: State insurance law may prohibit the owner of a life policy from entering into any agreement to sell, transfer or assign a life 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.

19. INSURANCE: EXISTING and APPLIED FOR

a. Have you applied for any Life or Health Insurance in the last 12 months or is any other application pending or contemplated? Yes No

Company Name	Policy Type	Business or Personal	Policy Number	Effective Date	Amount	Replacing?
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No
						<input type="checkbox"/> Yes <input type="checkbox"/> No

b. Have you ever had an application for Life or Health insurance declined, rated, postponed or otherwise modified? Yes No

20. OCCUPATION:

Name of Occupation: System Engineer
Name of Employer: Eastman Corporation

21. MILITARY:

Are you an Active duty service member of the United States Armed Forces? Yes No

SENTRY LIFE INSURANCE COMPANY

1800 NORTH POINT DRIVE
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SENTRY LIFE INSURANCE COMPANY

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22. INCOME:

- a. What is your annual earned income? \$ 100,000
b. Do you have any additional unearned income? \$ 225,000
c. What is your total household income? \$ 450,000
d. What is your approximate personal net worth? \$ 750,000
e. Have you ever filed for bankruptcy? [X] Yes [] No
f. Have you ever had any financial judgments brought against you, or had any repossessions, foreclosures, collections, bad debts, suits, tax liens or legal actions pending? [] Yes [X] No

23. GENERAL INFORMATION:

- a. What is your driver's license number and state of issue? Lic. #: D12312312301 State: AR
b. In the last 5 years have you had your driver's license suspended or revoked? [] Yes [X] No
c. In the last 5 years have you plead guilty to or been convicted of any moving violations or been involved in any accident in which you were found at fault? [] Yes [X] No
d. In the last 5 years have you been convicted of driving while impaired, intoxicated or under the influence of any drug? [X] Yes [] No
e. Have you ever been convicted of a felony or misdemeanor or are charges currently pending against you? [] Yes [X] No
f. Within the last 2 years, have you piloted an aircraft, or do you hold a valid pilot's license? [] Yes [X] No
g. Have you ever engaged in or do you intend within the next 2 years to engage in the following activities: motorized racing, scuba diving, skydiving, parachuting, hang-gliding, bungee jumping, mountain climbing, boat racing, spelunking, boxing, wrestling or ballooning? [X] Yes [] No
h. In the last 2 years, have you traveled outside of the United States? [] Yes [X] No
i. If yes, what city? [] Country? [] Year? [] Length of time visited? [] Reason? []
j. In the next 2 years, do you anticipate doing so? [] Yes [X] No

24. Life Insurance Application Part 2 Medical History

- a. Name of Personal Physician [Dr. John Johnson] (if none, state so)
b. Address of Personal Physician [2 Medical Drive, Ste 200, Anytown AR, 54476]
c. Last Visit [05/12/11] Reason Last Seen: [Physical]
Diagnosis/Treatment: [Healthy]
d. What is your Height? [6'0"] Weight? [190] Any weight loss in the last 12 months? [No]
e. Are you currently pregnant? [] Yes [X] No
Due Date: [] Prepregnancy Weight: []
Have you ever had any of the following complications or problems with current or past pregnancies: gestational diabetes, toxemia/high blood pressure, cesarean section, premature labor, placenta previa or ectopic pregnancy? [] Yes [X] No
f. Have you in the last three years used any form of tobacco, nicotine or nicotine replacement therapy (including cigarette, cigar, pipe, chewing tobacco, Nicorette gum, E-cig, nicotine patch or nasal spray?) [X] Yes [] No
Type: [Cigarettes]
g. Other than as prescribed by a physician, have you used cocaine, heroin, morphine, LSD, marijuana, PCP or any other hallucinogenic or narcotic drug during the past ten years? [] Yes [X] No
Name of drug: []
h. Do you presently use alcoholic beverages? [X] Yes [] No
Type: [Beer]

SENTRY LIFE INSURANCE COMPANY

**1800 NORTH POINT DRIVE
STEVENS POINT, WI 54481**



Policy Number: **67-2294572**

24. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:

- 1. Any disorder or disease of the brain, nervous system or mental health disorder; Yes No
- 2. Any disorder or disease of the respiratory system; Yes No
- 3. Any disorder or disease of the heart, blood vessels or circulatory system; Yes No
- 4. Any disorder or disease of the stomach, liver, intestines, rectum, pancreas or abdominal organs; Yes No
- 5. Any disorder or disease of the genito-urinary organs; Yes No
- 6. Any disorder or disease of the blood, thyroid, or endocrine system; Yes No
- 7. Any cancer, tumor, cyst or disorder of the skin or lymph glands; Yes No
- 8. Any disorder or disease of the skeletal system or immune system other than HIV; Yes No
- 9. Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV). Yes No

Other than already mentioned, have you within the last 5 years:

- 10. Been a patient in any hospital, sanitarium, or other medical institution? Yes No
- 11. Been treated for a condition or taken medications? Yes No
- 12. Advised to have a surgery or medical test? Yes No
- 13. Consulted a physician, psychiatrist or other practitioner? Yes No
- 14. Ever received Workers' Comp, Social Security, disability, or other disability payments? Yes No

15. FAMILY HISTORY: Have you had a parent or sibling diagnosed or treated by a member of the medical profession for the following conditions: heart or cerebrovascular disease, cancer or diabetes? Yes No

Relationship	Age if Living	Condition Diagnosis	Age at Onset of Condition	Age at Death	Cause of Death
Father		Lung Cancer	58	70	Cancer
Mother	70				

Comments (details of "YES" answers):

SENTRY LIFE INSURANCE COMPANY

1800 NORTH POINT DRIVE
STEVENS POINT, WI 54481



Policy Number: _____

ADDITIONAL BENEFICIARIES

Notice: Unless you specify otherwise, payments will be shared equally by all primary beneficiaries who survive the Proposed Insured(s) or, if none, by all contingent beneficiaries who survive the Proposed Insured(s). The right to change the beneficiary is reserved to the Owner unless otherwise stated.

16e. Additional Beneficiary *irrevocable <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Primary <input type="checkbox"/> Contingent * default is "No" if box is not checked	
First Name: _____	If other than individual, give full name _____
Middle Name: _____	
Last Name: _____	Date of Birth (mm/dd/yyyy): _____
Name of Trustee: _____	SSN # / TIN #: _____
Date of Trust Agreement: _____	Relation to Proposed Insured: _____
	% Benefit: _____
16f. Additional Beneficiary *irrevocable <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Primary <input type="checkbox"/> Contingent * default is "No" if box is not checked	
First Name: _____	If other than individual, give full name _____
Middle Name: _____	
Last Name: _____	Date of Birth (mm/dd/yyyy): _____
Name of Trustee: _____	SSN # / TIN #: _____
Date of Trust Agreement: _____	Relation to Proposed Insured: _____
	% Benefit: _____
16g. Additional Beneficiary *irrevocable <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Primary <input type="checkbox"/> Contingent * default is "No" if box is not checked	
First Name: _____	If other than individual, give full name _____
Middle Name: _____	
Last Name: _____	Date of Birth (mm/dd/yyyy): _____
Name of Trustee: _____	SSN # / TIN #: _____
Date of Trust Agreement: _____	Relation to Proposed Insured: _____
	% Benefit: _____
16h. Additional Beneficiary *irrevocable <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Primary <input type="checkbox"/> Contingent * default is "No" if box is not checked	
First Name: _____	If other than individual, give full name _____
Middle Name: _____	
Last Name: _____	Date of Birth (mm/dd/yyyy): _____
Name of Trustee: _____	SSN # / TIN #: _____
Date of Trust Agreement: _____	Relation to Proposed Insured: _____
	% Benefit: _____



SENTRY LIFE INSURANCE COMPANY
1800 NORTH POINT DRIVE
STEVENS POINT, WI 54481

Individual Life Insurance
Amendment of Application

This amendment forms part of the application dated: [03-26-2012]
for policy number: [67-2294573]
on the life of: [John C Doe]

[Issue policy with the Owner's social security number as: 123-45-6789.]

No other provisions are changed.

SENTRY LIFE INSURANCE COMPANY

[*Mark Stahl*]
President

Each person signing the Individual Life Insurance - Amendment of Application form agrees that all representations made in this form are true and complete to the best of their knowledge and belief on the date signed below.

[<i>John Doe</i>]	[03-26-2012]
Proposed Insured	Date
[]	[]
Proposed Insured and/or Parent or Guardian	Date
[<i>Jennifer Alice</i>]	[03-26-2012]
Officer of the Company other than Proposed Insured	Date
[]	[]
Other	Date

INSTRUCTIONS TO SALES PRODUCER:

- If joint policy, both Proposed Insureds must sign.
- This amendment must be dated and signed before delivery of the policy and returned to Sentry Life Insurance Company-Life Policy Issue.



Sentry Life Insurance Company

1800 North Point Drive
Stevens Point WI 54481
1-800-533-7827

} Referred to as "Sentry"

SUPPLEMENT TO INDIVIDUAL LIFE INSURANCE APPLICATION

ID# 1085333
(Enter ID# from submitted Proposal(s).)

BANK CHECK PAYMENT AUTHORIZATION

Check One: Checking Savings

TO: SENTRY LIFE INSURANCE COMPANY

I hereby request and authorize you to debit my checking or savings account maintained at the below named financial institution for the payment to Sentry Life Insurance Company (Sentry) of premiums due on all insurance policies referenced below and renewals thereof. It is agreed that:

1. Any requirement for giving notice of premiums due shall be waived as long as the automatic payment plan is in effect. No premium or portion thereof shall be deemed to have been paid unless Sentry receives actual payment at its Home Office. If there are insufficient funds at the date of deduction, you may request collection again with any charges for the initial non-payment or second request to be paid by me. The use of this plan shall in no way alter or amend the provisions of any policy upon non-payments of the premium due.
2. If this authorization pertains to a policy issued, on which the mode of payment is now other than monthly, this shall constitute an election to alter such mode to a monthly basis.
3. It will not be necessary for any officer or employee of Sentry to sign such debits.
4. Sentry shall incur no liability by reason of the dishonor of any such debit.
5. This payment plan shall continue in effect unless terminated by Sentry or me by thirty (30) days written notice to the other party. In addition, Sentry may terminate the plan immediately if any debit is not paid upon presentation.

03-16-12 6541541 John Doe
 Date Account Number Signature of Depositor As it Appears On Record

SENTRY LIFE INSURANCE COMPANY

AUTHORIZATION TO HONOR DEBITS DRAWN BY AND PAYABLE TO SENTRY LIFE INSURANCE COMPANY, STEVENS POINT, WI

To: (Bank Name) The Pineries Bank

Branch Name The Pineries Bank and Associations

Address 600 Any Street Anytown AR 91701
 Street City State Zip

**ATTACH VOID CHECK HERE
(Do Not Attach Deposit Slip)**

As a convenience to me, I hereby authorize you to pay and charge to my checking or savings account debits drawn by and payable to the order of Sentry Life Insurance Company (Sentry), Stevens Point, Wisconsin, whether or not made electronically, provided there are sufficient collected funds in said account to pay the same upon presentation. It will not be necessary for any officer or employee of Sentry to sign such debits. I agree that your rights in respect to each such debits shall be the same as if it were a debit drawn on you and signed personally by me. This authority is to remain in effect until revoked by me in writing.

03/16/2012 6541541 John Doe
 Date Account Number Signature of Depositor

To: The Financial Institution Named Above

In consideration of your participation in a plan by which amounts payable to Sentry Life Insurance Company (Sentry) are collected by debits drawn by and payable to the order of Sentry on the accounts of persons who are responsible for these payments, Sentry does hereby agree that:

1. The presentation by Sentry, whether or not done electronically, of any such item for payment by you shall constitute the warranty of Sentry that it holds your depositor's written authorization to draw it. You shall have no obligation in the processing of such items beyond ascertaining that such items are payable to Sentry and are endorsed for deposit by Sentry.
2. It will indemnify and hold you harmless from any liability to any person having an account with you arising out of a payment by you, or out of a dishonor by you, whether with or without cause or intentionally or inadvertently, of any debit drawn by Sentry on the account of such person; and it will indemnify and hold you harmless from any liability to any person making claim under any policy of insurance with respect to which debits are drawn, whether arising by policy lapse, forfeiture or otherwise.
3. It will refund to you any amount erroneously paid by you on any such debit.

SENTRY LIFE INSURANCE COMPANY

By: Ken J. [Signature] Secretary

340-1608



1085333



340-1608

DOC SCAN



**Sentry Life
Insurance Company**

1800 North Point Drive
Stevens Point WI 54481
1-800-533-7827

} Referred to as "Sentry"

**SUPPLEMENT TO INDIVIDUAL LIFE
INSURANCE APPLICATION**

ID# 1085333

(Enter ID# from submitted Proposal(s).)

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, and what happens while your application(s) is/are being processed. So, we've written your policy 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 receive from doctors or medical facilities; consumer reports;
- the Medical Information Bureau.

The consumer report may be obtained through personal interviews with your neighbors, friends, employers, or others you know. You may request to be interviewed in connection with the preparation of the consumer report. This report includes information regarding your character, general reputation, personal characteristics and lifestyle. If you make a written request, we will mail to you a complete and accurate account of the nature and scope of any investigation we have requested, within five 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 law. Information for consumers about MIB 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 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 company, MIB upon request, will supply such company with the information about you in its file.

You have access to your records. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of information in the 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 the MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

You may obtain the nature of any personal information Sentry maintains concerning you, and, if necessary, seek a correction by writing or calling Corporate Relations, Sentry Life Insurance Company, 1800 North Point Drive, Stevens Point, WI 54481, (715) 346-6225, you will be sent an inquiry form to be completed and returned to us.

SERFF Tracking Number: SLIN-128456905 State: Arkansas
Filing Company: Sentry Life Insurance Company State Tracking Number:
Company Tracking Number: 340-474
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Individual Life Insurance Application
Project Name/Number: Individual Life Insurance Application/340-474

the completed form to Sentry's Home Office. This form does not become part of the policy.

Attachment:

340-1004 Notice of Intent to Insure and Consent by Proposed Insured.pdf

Item Status: **Status**
Date:

Satisfied - Item: 340-475 Medical Examiner's Report

Comments:

The Medical Examiner's Report is completed by an outside nurse or doctor when a medical exam is performed. The form is return to Sentry's Home Office Life underwriting department for determining insurability of the applicant. This form does not become part of the policy.

Attachment:

340-475 Medical Examiner's Report.pdf

Item Status: **Status**
Date:

Satisfied - Item: 340-171 AR Good Health
Statement

Comments:

Two copies of the Good Health Statement are sent with every Life policy and are required to be completed by the Sales Producer and Proposed Insured prior to the policy being delivered to verify that there has been no change in the health of the Proposed Insured. One copy is returned to Sentry's Home Office and the other copy is for the Proposed Insured's records. If the Proposed Insured's health has changed the Sales Producer is instructed to contact underwriting. The policy may or may not be delivered. This form was previously filed and approved on March 17, 2010.

Attachment:

340-171 AR Good Health Stmt.pdf

Item Status: **Status**
Date:

Satisfied - Item: 340-418 Important Notice -
Replacement of Life Insurance or
Annuities

Comments:

The Important Notice Regarding - Replacement of Life Insurance or Annuities form may print with the proposal based on the Proposed Insured's answer to existing life insurance or annuity coverage. The forms are completed by the Sales Producer and Proposed Insured. The Sales Producer will return the completed form to Sentry's Home Office. The form

SERFF Tracking Number: SLIN-128456905 State: Arkansas
Filing Company: Sentry Life Insurance Company State Tracking Number:
Company Tracking Number: 340-474
TOI: L08 Life - Other Sub-TOI: L08.000 Life - Other
Product Name: Individual Life Insurance Application
Project Name/Number: Individual Life Insurance Application/340-474

does not become part of the policy.

Attachment:

340-418 Replacement Notice.pdf

Item Status: **Status**
Date:

Satisfied - Item: Statement of Variability and Life
Application Data Elements

Comments:

The Statement of Variability describes the variable sections of the forms. The Life Application Data Elements form reflects the complete application all sections, questions, drop downs, scripts and questionnaires that will be asked to the applicant to complete the Individual Life application for themselves and their dependents if applicable.

Attachments:

STATEMENT OF VARIABILITY- Generic.pdf
Life Application Data Elements - Generic.pdf

Item Status: **Status**
Date:

Satisfied - Item: 340-351 Agent's Replacement
Report

Comments:

The Agent's Replacement Report and state specific replacement forms print with the proposal based on the Proposed Insured's answer to existing life insurance or annuity coverage. The forms are completed by the Sales Producer and Proposed Insured. The Sales Producer will return the completed forms to Sentry's Home Office. The forms do not become part of the policy.

Attachment:

340-351 Agent's Replacement Report.pdf

Item Status: **Status**
Date:

Satisfied - Item: 340-79 Notice and Consent Form
For AIDS Virus (HIV) Testing

Comments:

This form would be completed only if blood is drawn. The form is return to Sentry's Home Office. This form does not become part of the policy.

SERFF Tracking Number: SLIN-128456905 *State:* Arkansas
Filing Company: Sentry Life Insurance Company *State Tracking Number:*
Company Tracking Number: 340-474
TOI: L08 Life - Other *Sub-TOI:* L08.000 Life - Other
Product Name: Individual Life Insurance Application
Project Name/Number: Individual Life Insurance Application/340-474

Attachment:

340-79 Notice and Consent Form for AIDS Virus (HIV).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



SENTRY®
LIFE INSURANCE
COMPANY

KEEP THIS NOTICE WITH YOUR INSURANCE AND ANNUITY PAPERS

QUESTIONS ABOUT YOUR INSURANCE OR ANNUITY?

If you have any questions, you may contact your insurance company or producer at:

**Sentry Life Insurance Company
Customer Service
1800 North Point Drive
Stevens Point, WI 54481
1 (800) 533-7827
1 (715) 346-6000**

Producer's Name: _____

Address: _____

Address: _____

Telephone Number: _____

If we, at Sentry Life Insurance Company, fail to provide you with reasonable and adequate service, you should feel free to contact:

Arkansas Insurance Department
1200 West Third Street
Little Rock, AR 72201-1904
1 (800) 852-5494
1 (501) 371-2640

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

800 533-7827
715 346-7516 Fax



FLESCH SCORE CERTIFICATION

I hereby certify to the best of my knowledge that the following application and supplemental forms, 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 Application	340-474	58.8
Individual Life Insurance Application - Amendment of Application	340-1606	55.7
Receipt/Temporary Life Insurance Agreement	340-1607	50.5
Bank Check Payment Authorization	340-1608	52.1
Important Notice, Keep For Your Records	340-1609	50.2
Authorization	340-1610	50.7

Kenneth Erler

Signature

Kenneth Erler

Name

Secretary, Sentry Life Insurance Company

Title

June 7, 2012

Date

U.S. Military Personnel Life Insurance Disclosure and Acknowledgement

Name of U.S. Military Personnel (please print)

I hereby acknowledge each of the following statements by placing an (x) in front of each statement.

- I do not reside on any U.S. Military Installation, Federal Land or other Federally Controlled Property.
- I am aware that subsidized life insurance is available to me as a member of the Armed Forces from the Federal Government under the Servicemembers' Group Life Insurance program (also referred to as "SGLI"), under subchapter III of chapter 19 of title 38, United States Code;
- I am aware of the amount of insurance coverage available to me under the SGLI program, together with the costs to me as a member of the Armed Forces for such coverage and prefer to purchase Life Insurance Protection from Sentry Life Insurance Company.
SGLI Death Benefit Available: \$ _____ SGLI Premium: \$ _____
- The Life Insurance Policy that I am applying for is being offered by Sentry Life Insurance Company and is not offered or provided by the Federal Government, and the Federal Government has in no way sanctioned, recommended, or encouraged the sale of the life insurance product being offered.
- I have been informed that if the life policy I am applying for contains a premium loan feature and I do not pay the policy premiums, the cash value of the policy, if any, will be used to pay the policy premium and these loans will be subject to an interest charge.
- I received an explanation of any free look period with instructions on how to cancel if the policy is issued.
- I received a complete copy of the proposed Life Policy's Policy Illustration or Policy Summary which illustrates the policy's projected premiums, death benefits and any guaranteed or non-guaranteed values.

I hereby acknowledge:

Signature of U.S. Military Personnel

Date

Statement and Acknowledgement by Sentry Life Insurance Company Agent:

Name of Sentry Life Insurance Company Agent (please print)

I am Licensed in the State of _____ to sell Sentry Life Insurance Company. I will receive a commission for this product sale from Sentry Life Insurance Company. No other person shall receive any referral fee or incentive compensation in connection with the offer or sale of this life insurance product, unless such person is a licensed agent of the person engaged in the business of insurance that is issuing such product.

I hereby acknowledge as an Agent of Sentry Life Insurance Company:

Signature of Sentry Life Company Insurance Agent

Date

340-539

3/08 (✓)



1085333



340-539

DOC SCAN

Notice of Intent to Insure and Consent by Proposed Insured



Date:

Proposed Insured:

Maximum Amount of Life Insurance Coverage Applied for: \$ by

Company Name/Employer

Address

City, State, Zip

The Proposed Insured qualified as a:
(Please check all that apply and at least one must be checked)

- Director
- 5% or Greater Owner of the Company at any time during the preceding year.
- Received Compensation in Excess of \$105,000 in the preceding year.
- One of the five highest Paid Officers.
- Among the Highest Paid 35% of All Employees.

I, , hereby have been notified that
 Print Name of Proposed Insured
 will apply for a Maximum Amount of Life Insurance
 Print Name of Company/Employer
of \$ on my life and I hereby consent that the Company be the Owner and
Maximum Amount

Beneficiary of any proceeds payable under said Life Insurance Policy on my life during employment
or after I terminate my employment or association with said Company/Employer.

Signature of Proposed Insured

Date

Acknowledgement of Signature: I witnessed the Signature of the Proposed Insured.

Print Name and Title

Signature and Title

Date

340-1004

10/08(✓)



1085333



340-1004

DOC SCAN

Sentry Life Insurance Company

1800 North Point Drive
Stevens Point, WI 54481
1 (800) 533-7827



SENTRY
LIFE INSURANCE
COMPANY

GOOD HEALTH STATEMENT

Supplementary Life Insurance Application for Policy Number: 672294580

on the life of: John C Doe

Since the date Part 1 of the life insurance application was completed for the above identified policy, has the proposed insured, or any eligible child(ren) to be insured under the Children's Term Life Insurance Rider, if applicable, under such policy:

1. been examined, advised or treated by any member of the medical profession other than any medical exams required by and completed for Sentry Life Insurance Company
2. applied for or received other life or health insurance
3. changed their aviation activities
4. changed their occupation
5. had a change in health of any kind

<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No
<input type="checkbox"/> Yes	<input checked="" type="checkbox"/> No

Give details to any "Yes" answers. Identify the person(s) involved and give the complete name and address of any member of the medical profession consulted.

Questions were asked of me, the proposed insured; or, if applicable, of parent(s) of the proposed insured listed on the application for the above identified policy. Please review all information before signing.

I understand that these statements and answers will be made part of the application attached to the above identified policy and together with such application will form the basis of issuing the policy to me. I declare that each of the above statements is true and complete to the best of my knowledge and belief.

John Doe

Proposed Insured (Print if under age 15)

04-12-2012

Date

Parent (If Proposed Insured is under age 15)

Date

Jeanette Miller

Writing Agent Signature

26999996

Salescode

340-171 AR

3/10



672294580



340-171 AR

DOC SCAN

**Sentry Life
Insurance Company**

1800 North Point Drive
Stevens Point, WI 54481



SENTRY
INSURANCE

IMPORTANT NOTICE
REPLACEMENT OF LIFE INSURANCE OR ANNUITIES
This document must be signed by the applicant and the producer,
if there is one, and a copy left with the applicant.

You are contemplating the purchase of a life insurance policy or annuity contract. In some cases this purchase may involve discontinuing or changing an existing policy or contract. If so, a replacement is occurring. Financed purchases are also considered replacements.

A replacement occurs when a new policy or contract is purchased and, in connection with the sale, you discontinue making premium payments on the existing policy or contract, or an existing policy or contract is surrendered, forfeited, assigned to the replacing insurer, or otherwise terminated or used in a financed purchase.

A financed purchase occurs when the purchase of a new life insurance policy involves the use of funds obtained by the withdrawal or surrender of or by borrowing some or all of the policy values, including accumulated dividends, of an existing policy to pay all or part of any premium or payment due on the new policy. A financed purchase is a replacement.

You should carefully consider whether a replacement is in your best interest. You will pay acquisition costs and there may be surrender costs deducted from your policy or contract. You may be able to make changes to your existing policy or contract to meet your insurance needs at less cost. A financed purchase will reduce the value of your existing policy and may reduce the amount paid upon the death of the insured.

We want you to understand the effects of replacements before you make your purchase decision and ask that you answer the following questions and consider the questions on the next page of this form.

1. Are you considering discontinuing making premium payments, surrendering, forfeiting, assigning to the insurer, or otherwise terminating your existing policy or contract? Yes No
2. Are you considering using funds from your existing policies or contracts to pay premiums due on the new policy or contract? Yes No

If you answered "yes" to either of the above questions, list each existing policy or contract you are contemplating replacing (include the name of the insurer, the insured or annuitant, and the policy or contract number if available) and whether each policy or contract will be replaced or used as a source of financing:

	INSURER NAME	CONTRACT OR POLICY #	INSURED OR ANNUITANT	REPLACED (R) OR FINANCING (F)
1.				
2.				
3.				

Make sure you know the facts. Contact your existing company or its agent for information about the old policy or contract. (If you request one, an in-force illustration, policy summary, or available disclosure document must be sent to you by the existing insurer.) Ask for and retain all sales material used by the agent in the sales presentation. Be sure that you are making an informed decision.

The existing policy or contract is being replaced because

I certify that the responses herein are, to the best of my knowledge, accurate:

Applicant's Signature and Printed Name

Date

Producer's Signature and Printed Name

Date

I do not want this notice read aloud to me. (Applicants must initial only if they do not want the notice read aloud.)

A replacement may not be in your best interest, or your decision could be a good one. You should make a careful comparison of the costs and benefits of your existing policy or contract and the proposed policy or contract. One way to do this is to ask the company or agent that sold you your existing policy or contract to provide you with information concerning your existing policy or contract. This may include an illustration of how your existing policy or contract is working now and how it would perform in the future based on certain assumptions. Illustrations should not, however, be used as a sole basis to compare policies or contracts. You should discuss the following with your agent to determine whether replacement or financing your purchase makes sense:

PREMIUMS:

Are they Affordable?

Could they change?

You're older - are premiums higher for the proposed new policy?

How long will you have to pay premiums on the new policy? On the old policy?

POLICY VALUES:

New policies usually take longer to build cash values and to pay dividends.

Acquisition costs for the old policy may have been paid; you will incur costs for the new one.

What surrender charges do the policies have?

What expense and sales charges will you pay on the new policy?

Does the new policy provide more insurance coverage?

INSURABILITY:

If your health has changed since you bought your old policy, the new one could cost you more, or you could be turned down.

You may need a medical exam for a new policy.

(Claims on most new policies for up to the first two years can be denied based on inaccurate statements. Suicide limitations may begin anew on the new coverage.)

IF YOU ARE KEEPING THE OLD POLICY AS WELL AS THE NEW POLICY:

How are premiums for both policies being paid?

How will the premiums on your existing policy be affected?

Will a loan be deducted from death benefits?

What values from the old policy are being used to pay premiums?

IF YOU ARE SURRENDERING AN ANNUITY OR INTEREST SENSITIVE LIFE PRODUCT:

Will you pay surrender charges on your old contract?

What are the interest rate guarantees for the new contract?

Have you compared the contract charges or other policy expenses?

OTHER ISSUES TO CONSIDER FOR ALL TRANSACTIONS:

What are the tax consequences of buying the new policy?

Is this a tax-free exchange? (See your tax advisor.)

Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code?

Will the existing insurer be willing to modify the old policy?

How does the quality financial stability of the new company compare with your existing company?

**SENTRY LIFE INSURANCE COMPANY
STATEMENT OF VARIABILITY
INDIVIDUAL LIFE INSURANCE APPLICATION AND
INDIVIDUAL LIFE INSURANCE APPLICATION AND SUPPLEMENTAL FORMS
FORMS 340-474, 340-1606, 340-1607, 340-1608, 340-1609, 340-1610
MAY 31, 2012**

Variable information for all forms is indicated by brackets.

340-474, INDIVIDUAL LIFE INSURANCE APPLICATION

Pages 1 through 7

- The Company's address is bracketed for administrative purposes.
- The Product Applied For/Face Amount, Policy Number, Creation Date/Time, all questions, "Yes" and "No" responses and signatures are variable as they are specific to the Proposed Insured and their dependents. The Sales Producer/Agent's signature and printed name are also specific to the writing Sales Producer/Agent. Refer to the Life Application Data Elements attachment for specifics which reflects the complete application all sections, questions, drop downs, scripts and questionnaires that will be asked to the Proposed Insured to complete the Individual Life Insurance Application for themselves and their dependents if applicable.
- The data that will transfer from the Proposal Summary to the Individual Life Insurance Application will be the Policy Number, Creation Date/Time, Proposed Insured's Name, Product Applied For, Face Amount, Proposed Insured's Address, Date-of-Birth, Payment Mode, Child Rider Units, Automatic Premium Loan and Rider choices; Children Benefit; Waiver of Premium, Guaranteed Insurability and Accelerated Death Benefit. The rider information transferred will be specific to each Proposed Insured and the product selected. The External Call Center will use the transferred information to complete the electronic signature application and obtain the voice signatures of the Sales Producer/Agent, Proposed Insured and Policyowner(s).

340-1606, INDIVIDUAL LIFE INSURANCE APPLICATION – AMENDMENT OF APPLICATION

Page 1

- The Company's address is bracketed for administrative purposes.
- The following sections are bracketed as variable as the information will be specific to the Proposed Insured: "This amendment forms part of the application dated:", "the policy number" and "on the life of:"
- The blank space under "on the life of:" will be used for corrections or updates to the information initially submitted on the Individual Life Insurance Application; such as updating beneficiary information, date-of-birth or social security numbers; see below for the variable language that may be printed on this form:
 - ❖ Issue policy with the correct spelling of the Proposed Insured's name as: [NAME].
 - ❖ Issue policy with the following Primary Beneficiary Designation as Primary Beneficiary: [NAME(S)].

- ❖ Issue policy with the following Contingent Beneficiary Designation as Contingent Beneficiary: [NAME(S)].
- ❖ Issue policy with the answer to question number [###], as: [].
- ❖ Issue policy with the Proposed Insured's social security number as: [###-##-####].
- ❖ Issue policy with the Owner's social security number as: [###-##-####].
- ❖ Issue policy with the Payor as: [NAME(S)].
- ❖ Issue policy with the Proposed Insured's date of birth as: [MMDDYYYY].
- ❖ Issue policy with the Proposed Insured's age as: [###].
- ❖ Issue policy with the Proposed Insured's gender as: [Male or Female].
- ❖ Issue policy with following as the Policy Owner: [NAME(S)].
- ❖ Issue policy with the insurance exam date as: [MMDDYYYY].
- ❖ Issue policy with the policy effective date as: [MMDDYYYY].
- ❖ Issue policy with the application dated: [MMDDYYYY].
- ❖ Issue policy with the application dated at: [MMDDYYYY].
- ❖ Issue policy with the Children's Benefit.
- ❖ Issue policy including the Children's Benefit on the following: [NAME(S)].
- ❖ Issue policy without the Children's Benefit.
- ❖ Issue policy without the Children's Benefit on the following: [NAME(S)].
- ❖ Issue policy with the Guaranteed Insurability Benefit in the amount of: [\$10,000 to \$20,000].
- ❖ Issue policy without the Guaranteed Insurability Benefit:
- ❖ Issue policy with the Extended Rate Guaranty for: [10, 15, 20 or 30] years.
- ❖ Issue policy without the Extended Rate Guaranty.
- ❖ Issue policy with Waiver of Premium Benefit.
- ❖ Issue policy without Waiver of Premium Benefit.
- ❖ Issue policy with Accidental Death Benefit in the amount of: \$ [No more than two times the face amount].
- ❖ Issue policy without Accidental Death Benefit.
- ❖ Issue policy with the Children's Benefit with the following number of units: [1 to 20].
- ❖ It is understood and agreed that this policy is issued with an extra annual premium of: \$ [####.##].

- ❖ Issue policy with the following rate classification: [Super Preferred Non-Tobacco, Preferred Non-Tobacco, Standard Non-Tobacco, Preferred Tobacco and Standard Non-Tobacco].
 - ❖ Issue policy with the following special rate classification: [Table B to Table P] for [1 to the life of the policy] years.
 - ❖ Issue policy with the following special rate classification: [Table B to Table P] for [a flat extra charge of \$2.50 to \$20.00 per \$1,000 of coverage annually] premium.
 - ❖ Issue policy for the following amount of insurance coverage: [\$25,000 to unlimited].
 - ❖ Issue the following plan of insurance: [Level Benefit Term Life Insurance to Age 95; 10, 15, 20 or 30 Year Level Premium or Whole Life Insurance Paid-Up At Age 100].
 - ❖ The ultimate total line will not exceed [\$25,000 to unlimited] which includes all life insurance pending and in force.
 - ❖ Issue policy [with or for]: [for a reason not specified in the above list].
- The Officers' signature and title are bracketed for administrative purposes.
 - The Proposed Insured, Parent or Guardian, Officer of the Company other than Proposed Insured and Other signature lines are variable and specific to each policy applied for.

340-1607, RECEIPT-TEMPORARY LIFE INSURANCE AGREEMENT

Page 1

- The Company's address and phone number are bracketed for administrative purposes.
- In the **Receipt** section; the ID number is transferred from the Proposal Summary and is specific to each Proposed Insured.
- The Plan of Insurance is variable and specific to the plan selected by the Policyowner.
- The amount of coverage, payor name, Proposed Insured's name, dated at, date and signature of the Sales Producer/Agent are variable and specific to each policy applied for.
- In the **Temporary Life Insurance Agreement** section, The Signature of Proposed Insured, Signature of Owner(s) and date are variable and specific to each policy applied for.

340-1608, BANK CHECK PAYMENT AUTHORIZATION

Page 1

- The Company's address and phone number are bracketed for administrative purposes.
- The Bank Check Payment Authorization asks the Proposed Insured and/or Policyowner to specify if the automatic bank draft will draw proceeds from their checking or savings account; therefore this information is variable and specific to each policy applied for.

- The Date, Account Number, Signature of Depositor, Bank Name, Branch Name and Address are variable and specific to each policy applied for.
- The officer's name and title are bracketed for administrative purposes.
- The barcode is bracketed as it will be specific to each Proposed Insured.

340-1609, IMPORTANT NOTICE, KEEP FOR YOUR RECORDS

Page 1

- The Company's address and phone number are bracketed for administrative purposes.
- The ID number is transferred from the Proposal Summary and is specific to each Proposed Insured.
- The address and phone number for the Medical Information Bureau (MIB) is bracketed in the event of change.

340-1610, AUTHORIZATION FOR INDIVIDUAL LIFE INSURANCE APPLICATION

Page 1

- The Company's address and phone number are bracketed for administrative purposes.
- The Proposed Insured's Name, Maiden or Other Name, Address, Date of Birth, request for authorization, Signature of Proposed Insured or Person Authorized to Consent, Relationship, Date Signed and Witness are bracketed as variable as they are specific to each policy applied for.
- The barcode is bracketed as it will be specific to each Proposed Insured.

Life Application Data Elements

Application # Section	Field Name	Description of Field	Transfer from Quote	Required f	Comments section /overflow page
Title 340-474	Life Insurance Application Part 1	Sentry Insurance address, logo and title Part 1 Individual Life Insurance Application			
Header	Policy Number	Number exactly as it appears on the policy			
Header	Creation Date/Time	Date and time application is completed	X		
1	Legal - First Name	First name of the proposed insured	X	X	
1	Middle initial	Middle initial of the proposed insured	X		
1	Legal -Last name	Last name of the proposed insured	X	X	
1	Suffix	Optional- if any exist from quote, will appear- otherwise ask, Senior, Junior, I, II, III etc.	X		
2	Product applied for	Insert the name of the product	X	X	
2	Face amount	Insert the face amount	X	X	
3	DOB	Indicate the date of birth of proposed insured using MM/DD/YYYY format	X	X	
3	Age	Calculated by DOB		X	
4	Birth Country	Indicate birth country of proposed insured		X	
4	Birth State/Province	Indicate the state/province of the proposed insured			
5	Marital status	Indicate the marital status of the proposed insured		X	
6	Are you a U.S. Citizen?	Check the appropriate box to indicate whether or not you are a U.S. Citizen.		X	
6	Date of arrival	Indicate date of arrival in the U.S			X
6	Country of Citizenship	If no, indicate your country of citizenship			
6a	Do you have a Permanent Visa? Yes or No	Indicate Yes or No if you retain a permanent visa			X
7	Gender	Check the appropriate box to indicate proposed insured is male or female	X	X	
8	Primary (Home, Cell, Work)	Select the appropriate type of Home, Cell, Work for primary phone number of proposed insured		X	
8	Phone Number	Indicate the phone number of the proposed insured, including the area code		X	
9	Email Address	The e-mail address of the proposed insured	X		X
10	SSN/Government ID	Social security number or Government Identification Number of Proposed insured			
11	Legal residence- Street Address 1 (no P.O. Box)	Indicate the legal residence of the proposed insured. Do not Use P.O. Box number.	X	X	
11	Street Address 2	Residence address line 2	X		
11	City	Indicate the city of the address	X	X	
11	State	State of the address	X	X	
11	Zip	Zip code, postal code, etc. (country dependent)	X	X	
Owner (collect if different than Proposed Insured)					

Life Application Data Elements

Application # Section	Field Name	Description of Field	Transfer from Quote	Required	Comments section /overflow page
	Indicate type of Ownership (Individual, Business or Trust)	Check the appropriate box to indicate type of owner	X	If one of the options are selected, then require appropriate fields for each type are entered	
12	First name	First name of the owner	X		
12	Middle initial	Middle initial of the owner	X		
12	Last Name	Last name of the owner	X		
12	Address 1 (No P.O. Box)	Indicate the address of the owner. Do not use a P.O. Box number.			
12	Address 2	Address line 2			
12	City	Indicate the city of the address			
12	State	Indicate the state/province of the proposed insured			
12	Zip	Zip code, postal code, etc. (country dependent)			
12	Relationship	Indicate the relation to the proposed insured			
12	SSN	Social security number of the Owner	X		
12	Business name	Indicate the Business name of the owner	X		
12	Address 1	Indicate the business address of the owner. Do not use a P.O. Box number.			
12	Address 2	Address line 2			
12	City	Indicate the city of the address			
12	State	Indicate the state/province of the proposed insured			
12	Zip	Zip code, postal code, etc. (country dependent)			
12	Relationship	Indicate the relation to the proposed insured			
12	TIN/FEIN #	Tax Identification Number or Federal Employment Identification Number of the owner	X		
12	Name of Trust	Name of the Trust	X		
12	Name of Trustee	Indicate the name of Trustee			
12	Date of Trust	Indicate the date of the Trust Agreement (MM/DD/YYYY)			
12	Location of Trust	Indicate the location of the trust, city, state, zip			
12a	Phone	Enter phone number of owner			X
12b	Email Address	Enter e-mail address of owner			X
Payor (collect if different than Proposed Insured)					

Life Application Data Elements

Application # Section	Field Name	Description of Field	Transfer from Quote	Required	Comments section /overflow page
	If payor if different than owner or insured ask the following otherwise ignore				
	Indicate type of Payor (Individual, Business or Trust)	Check the appropriate box to indicate type of payor		If one of the options are selected, then require appropriate fields for each type are entered	
13	First name (individual)	First name of the Payor			
13	Middle initial	Middle Initial of the Payor			
13	Last name	Last name of the Payor			
13	Address 1	Indicate the address of the payor. Do not use a P.O. Box number.			
13	Address 2	Address line 2			
13	City	Indicate the city of the address			
13	State	Indicate the state/province of the proposed insured			
13	Zip	Zip code, postal code, etc. (country dependent)			
13	Relationship	Indicate relation to the Proposed insured			
13	Business name (Business)	Business name of the Payor			
13	Address 1	Indicate the business address of the payor. Do not use a P.O. Box number.			
13	Address 2	Address line 2			
13	City	Indicate the city of the address			
13	State	Indicate the state/province of the proposed insured			
13	Zip	Zip code, postal code, etc. (country dependent)			
13	Relationship	Indicate the relation to the proposed insured			
13	Trust (Trust)	Name of Trust as the payor			
13	Address 1	Indicate the Trust address of the payor. Do not use a P.O. Box number.			
13	Address2	Address line 2			
13	City	Indicate the city of the address			
13	State	Indicate the state/province of the proposed insured			
13	Zip	Zip code, postal code, etc. (country dependent)			
14 Payment Mode	Payment mode (Annual, Semi-Annual, Quarterly, Monthly (PAC)	check the appropriate box to indicate payment mode	X	X	
15 Riders					

Life Application Data Elements

Application # Section	Field Name	Description of Field	Transfer from Quote	Required	Comments section /overflow page
15	Child Rider (Yes or No)	check appropriate box if a Child Rider was selected based on policy plan type	X		
15	Child Rider Units	Indicate total number of units for Child Term Rider	X		
15A	First name	First name of Child Rider			
15A	Last name	Last name of Child Rider			
15A	SSN/Government ID	Indicate Social Security number or Government Identification number of child rider			
15A	DOB	Date of birth of child rider			
15.A 1	Height ' "	Indicate the height of the child rider in feet and inches			X
15.A 2	Weight lbs.	Indicate the weight of the child rider			X
15.A 3	Personal Care Physician (PCP)	Indicate Primary Care Doctors name for Child Rider			X
15.A 4	Street Address 1	Indicate address of PCP			X
15.A 5	Street Address 2	Address line 2			X
15.A 6	City	Indicate the city of the address			X
15.A 7	State	Indicate the state/province of the proposed insured			X
15.A 8	Zip	Zip code, postal code, etc. (country dependent)			X
15.A 9	Last Visit Date	Indicate date (MM/DD/YYYY) of last visit of child rider			X
15.A 10	Last Visit Reason	Indicate the reason for the doctor visit			X
15.A 11	Last Visit Result	Indicate any results of the doctor visit			X
15.A 12	Has the child ever been treated for any medical conditions Not Already Noted?	If Yes, complete the remaining drop down questions, if No, skip the drop down questions			X
15.A 12a	Condition	Indicate the medical condition of the child rider			X
15.A 12b	Specialist Name	Indicate Specialist doctors name			X
15.A 12c	Specialty	Indicate the doctors specialty			X
15.A 12d	Street Address 1	Indicate the address of the specialists			X
15.A 12d	Street Address 2	Address line 2			X
15.A 12d	City	Indicate the city of the address			X
15.A 12d	State	Indicate the state/province of the proposed insured			X
15.A 12d	Zip	Zip code, postal code, etc. (country dependent)			X
15.A 13	Is the child currently taking any prescribed medications? Yes or No	If yes, complete the remaining medication questions, if no, skip			X
15.A 13a	name of medication	Indicate the name of each medication			X
15.A 13b	Dr. who prescribed the medication	Indicate the Doctors name that prescribed the medication			X
15.A 13c	Reason for taking medication	Indicate reason for prescribed medication			X
15	Automatic Premium Loan	Indicate whether or not there was an automatic premium loan		X	
15	Accidental Death Benefit	Indicate dollar amount if Accidental Death Benefit selected		X	

Life Application Data Elements					
Application # Section	Field Name	Description of Field	Transfer from Quote	Required	Comments section /overflow page
15	Waiver of Premium	Indicate whether or not there was Waiver of premium		X	
15	Guaranteed Insurability	Indicate dollar amount if Guranteed Insurability was selected		X	
Beneficiary					
16a		NOTE: If multiple beneficiaries are designated, benefits will be equally divided to all beneficiaries unless otherwise indicated.			
16a	Beneficiary Type (Primary or Contingent)	at least one primary listed - if no contingent beneficiaries enter NONE			
16a	Irrevocable	Check Yes or No box to indicate the beneficiary is irrevocable			
16a	First name	First name of beneficiary		X	
16a	Middle initial	Middle name of beneficiary		X	
16a	Last name	Last name of beneficiary		X	
16a	Full Name (If other than individual)	Full name of beneficiary			
16a	Date of Birth (only if individual)	Indicate the date of birth of beneficiary in MM/DD/YYYY format		X only if individual	
16a	SSN/TIN	Social security number or Tax Identification number of beneficiary		individual or business	
16a	% of Benefit	Indicate percentage of distribution for beneficiary		X	
16a	Relationship	Indcate the relation to the proposed insured		X	
16a	Name of Trust	Indicate the name of the Trust			
16a	Name of Trustee	Indicate the name of the Trustee			
16a	Date of Trust	Indicate the date of the Trust Agreement (MM/DD/YYYY)			
16a	Location of Trust	Indicate the location of the trust, city, state, zip			
Title 340-474	Life Insurance Application Part 1	Sentry Insurance address, logo and title Part 1 Individual Life Insurance Application			
Header	Policy Number	Number exactly as it appears on the policy			
		Note: If applicable, additional details for question responses are provided in the comments section.			
17	Indicate the purpose for purchasing this life insurance coverage? Personal, Buy/Sell, Key Person, Other	check appropriate box of Personal, Buy/Sell, Key Person or Other		X	
17a	Will this Policy be collaterally assigned? Yes or No	If yes, require name of lender to be entered		X	
17a	Name of Lender	Indicate name of Lender			
17	Name of Partners	If Buy/Sell or Key Person selected must fill out Partner and % of ownership questions			
17	Partner First name	First name of Partner			
17	Partner Middle initial	Middle initial of Partner			

Life Application Data Elements

Application # Section	Field Name	Description of Field	Transfer from Quote	Required	Comments section /overflow page
17	Partner Last name	Last name of Partner			
17	% of Ownership	Indicate percentage of Ownership on the life insurance policy			
18a	Do you have Life Insurance or Annuities in force? Yes or No	Check Yes or No to the questions regarding other insurance. If you answer "YES" please complete table.		X	
18b	Will this Life insurance or Annuity replace or change Life insurance or Annuity with this company or any other company? Yes or No	Check Yes or No to the questions regarding other insurance. If you answer "YES" please complete table.		X	
		Note: This would include insurance that is currently pending but bound by a temporary insurance agreement or conditional receipt.			
	Table for Proposed Insured or Owner				
18a/b	Policy Type- Life or Annuity	Indicate whether the policy type is Life or Annuity			
18a/b	Purpose - Business or Personal	Indicate whether the purpose of insurance is for business or personal			
18a/b	Company Name	Indicate name of company of other insurance			
18a/b	Policy Number	Indicate number exactly as it appears on the policy			
18a/b	Effective Date	Indicate the effective date of the policy			
18a/b	Amount	Indicate the amount of the insurance			
18a/b	Is this policy being replaced? Yes or No	Indicate if the insured has replaced insurance			
18c	Have you been offered any cash incentive or other consideration (such as free insurance) as an inducement to apply for this life application?	Check Yes or No			
	Insurance:Existing and Applied For				
19a	Have you applied for any Life or Health Insurance in the last 12 months or is any other application pending or contemplated? Yes or No	Check Yes or No to the questions regarding other insurance. If you answer "YES" please complete table.		X	
	Table for Proposed Insured or Owner				
19a	Policy Type- Life or Health	Indicate whether the policy type is Life or Health			X
19a	Purpose - Business or Personal	Indicate whether the purpose of insurance is for business or personal			X
19a	Company Name	Indicate name of company of other insurance			X
19a	Amount	Indicate the amount of the insurance			X
19a	Status	Indicate the status of the policy			X
19b	Have you ever had an application for Life or Health Insurance decline, rated, postponed or otherwise modified? Yes or No	If Yes, please complete the additional three questions below		X	
19b 1	Ever Asked to Pay a Higher Premium? Yes or No	Check the appropriate option			X

Life Application Data Elements					
Application # Section	Field Name	Description of Field	Transfer from Quote	Required f	Comments section /overflow page
19b 2	Ever Issued a Reduced Face Amount? Yes or No	Check the appropriate option			X
19b 3	Ever had a Withdrawn Application or Inquiry? Yes or No	Check the appropriate option			X
20 OCCUPATION	Name of Occupation	Describe the occupation of the proposed insured		X	
20.1	Duties	Describe the duties of the occupation			X
20	Name of Employer	The name of the employer			
20.2	Date of Hire	Indicate date of hire with MM/DD/YYYY format			X
21 Military	Are you an Active duty service member of the United States Armed Forces? Yes or No	check the appropriate box, if Yes selected, ask the following military questions		X	
21.1	Ever rejected for Service? Yes or No	check the appropriate option			X
21.2	Currently on Alert for Active Duty? Yes or No	check the appropriate option			X
21.3	Enlistment Start Date	Indicate enlisted start date MM/DD/YYYY format			X
21.4	Enlistment End Date	Indicate enlisted end date MM/DD/YYYY format			X
21.5	Which Organization do you belong to? (Branch, National Guard, etc)	Indicate which organization the proposed insured belongs to			X
21.6	Rank	Indicate the rank of the proposed insured			X
21.7	Pay Grade	Indicate the pay grade of the proposed insured			X
21.8	What were your Duties/Specialty?	Indicate the duties or speciality of the proposed insured			X
21.9	Where were you Stationed?				X
21.9	City	Indicate the city the proposed insured was stationed at			X
21.9	Country	Indicate the country the proposed insured was stationed at			X
21.10	Service Start Date	Indicate the service start date of where proposed insured was stationed			X
21.10	Service End Date	Indicate the service end date of where proposed insured was stationed			X
21.11	Have you ever been a member of a Flight Crew? Yes or No	If Yes, ask the Aviation questions			X
22 INCOME					
a	What is your annual earned income?	Indicate the annual income of the proposed insured		X	
b	Do you have any additional unearned income?	Indicate additional unearned income of the proposed insured		X	
c	What is your total household income?	Indicate the total household income of the proposed insured		X	
d	What is your approximate estimated Net Worth?	Indicate approximate net worth of proposed insured		X	
e	Have you ever filed for Bankruptcy? Yes or No	If yes, ask the Drop down questions below for more details on bankruptcy.		X	

Life Application Data Elements

Application # Section	Field Name	Description of Field	Transfer from Quote	Required	Comments section /overflow page
22 e.1	Date Filed	Indicate the date filed for bankruptcy use MM/DD/YYYY format			X
22 e.2	Current Status	Indicate the status of bankruptcy			X
22 e.3	Discharge Date	Indicate the discharge date use MM/DD/YYYY			X
22 e.4	Type	Indicate the type of bankruptcy filed- ex.- chapter 11, chapter 7 etc.			X
	Payment Details				X
22e.5	Monthly Payment Amount	Indicate monthly payment amount			X
22e.6	Payment End Date	Indicate the date the payments will end using MM/DD/YYYY			X
22e.7	Are Payments Current	Indicate if payments are current or past due			X
22f	brought against you or had any repossessions, foreclosures, collections, bad debts, suits, tax liens, or legal actions pending?	indicate yes or no if the proposed insured had any financial judgements		X	
	Details	If yes, explain each judgement			X
22 G	BASE INSURED UNDER 18				
22 G.1	What is the number of Children in the Household?	indicate the number of children within the proposed insureds household			X
22 G.2	Are all the Children Equally Insured?	Indicate yes or no			X
22 G.3	If Children are unequally Insured - Details	If no to question above, explain			X
22 G.4	What is the inforce Insurance Amount on parent/guardian?	Indicate the total inforce insurance amount on each parent of the child			X
GENERAL INFO					
23a	Drivers License Number	Indicate current proposed insured drivers license number		X	
23a	Drivers License State	indicate current state of proposed insured drivers license			
23b	In the Last 5 Year has your License been suspended or revoked?	Indicate Yes or No		X	
23c	In the last 5 Years have you plead guilty to or been convicted of any moving violation or been involved in any accident in which you were found at fault?	Indicate Yes or No		X	
23d	In the last 5 years have you been convicted of driving while impaired, intoxicated or under the influence of any drug?	Indicate Yes or No, if Yes ask the following detail questions		X	
23d.1	Name of each conviction	If yes, list the name of each conviction			X
23d.2	Conviction Date	Indicate the date of each conviction			X
23d.3	DL State	Indicate the drivers license state that the conviction was received			X
23d.4	DL #	Indicate the drivers license number that the conviction was received			X
23e	Have you ever been convicted of a felony or misdemeanor or are charges currently pending against you?	Indicate Yes or No		X	
	Convictions				X

Life Application Data Elements

Application # Section	Field Name	Description of Field	Transfer from Quote	Required	Comments section /overflow page
23e.1	Criminal Description	If yes, list name of conviction			X
23e.2	Fine Amount	Indicate the \$ amount of the fine			X
23e.3	Conviction Date	Indicate the date of the conviction using MM/DD/YYYY format			X
23e.4	Sentence Description	Indicate the sentence from the judge			X
	PROBATION			if yes to above question, ask probation que	
23e.5	Are you currently on Probation?	Indicate Yes or No			X
23e.6	What is the end date for your probation?	Indicate the end date of probation using MM/DD/YYYY format			X
	AVIATION				
23f	Within the last 2 years have you piloted an aircraft or do you hold a valid pilot's license?	Indicate Yes or no, if yes, proposed insured must answer the following aviation questions		X	
23f.1	What are your total solo hours flown?	Indicate the total number of hours flown solo			X
23f.2	What are your anticipated solo hours for the next 12 months?	Indicate hours within next 12 months to fly solo			X
23f.3	Do you have an Instrument Flight Rating (IFR)?	Indicate Yes or No			X
23f.4	Do you have an Airline Transport Rating (ATR)	Indicate Yes or No			X
23f.5	What type of Aircraft have you Flown?	Indicate the type of aircraft flown			X
23 f.6	Reason for flying this Aircraft please provide details	Indicate details of flying aircraft listed			X
23 f.7	Hours Flown in the Last 12 Months	Indicate total hours flown in last 12 months			X
23 f.8	Hours Flown within the Last 13-24 Months	Indicate total hours flown in last 13-24 months			X
23 f.9	Hours to fly within the next 24 Months	Indicate hours to fly in the next 24 months			X
23 f.10	Any Accidents?	Indicate Yes or No, If yes, ask for details			X
23 f.11	Accident Details	Describe the accident			X
23 f.12	Where you ever Grounded?	Indicate Yes or No, if yes ask for details			X
23 f.13	Grounded Details	Describe why grounded			X
23 f.14	Where you ever fined?	Indicate Yes or No, if yes ask for details			X
23 f.15	Fined Details	Describe why proposed insured was fined			X
23 f.16	Do you have any Certification?	Indicate Yes or No, if yes ask for details			X
23 f.17	Certification Rating Description	List all certifications related to aviation			X
23 f.18	Have you Flown or intend to fly outside the US?	Indicate Yes or No, if yes ask for details			X
23 f.19	Foreign Flight Details	Describe foregin flight details			X
23 f.20	Duties on aircraft other than piloting	Decribe all duties performed other than pilot			X
23g	Have you ever engaged or do you intend within the next two years to engage in the following activities: Motorized racing, Scuba Diving, Moutain Climbing, Sky Diving hang gliding, bungee jumping, boat racing, spelunking, wrestling, or ballooning.	Indicate Yes or No, list all activities proposed insured Yes, based on which type, following drill down questions		X	

Life Application Data Elements

Application # Section	Field Name	Description of Field	Transfer from Quote	Required	Comments section /overflow page
23 g.1	MOTORIZED RACING	If any type of motorized racing - ask the following drill down questions (boat, ATV, ATC, motor cross etc.)			
23 g.2	Average Speed Attained	Indicate the average speed			X
23 g.3	Max Speed Attained	Indicate the maximum speed			X
23 g.4	Average Race Distance	Indicate the average distance of the races			X
23 g.5	Professional Or For Cash	Indicate if the races are profession or for cash			X
23 g.6	Remarks	Indicate any comments from the above questions			X
23 g.7	List of Race Competitions (Grouped by Type and Timeframe)	Indicate name of race, and type of race and timeframe			X
23 g.8	Competition Class	Indicate what competition class			X
23 g.9	Vehicle Make	Indicate the vehicle make used in the race			X
23 g.10	Vehicle Model	Indicate the vehicle model used in the race			X
23 g.11	Engine Horsepower	Indicate the horsepower of the vehicle			X
23 g.12	Fuel Class	Indicate the fuel class of the vehicle			X
23 g.13	Number of Events	Indicate the number of events participated in at a race			X
23 g.14	Competition Miles	Indicate the number of miles per competition			X
23 g.15	Track Type	Indicate the type of track used within the competition			X
23 g.16	Surface Type	Indicate the surface type used within the competition			X
23 g.2	DIVING				
23 g.2.1	Do you Dive Alone?	If Yes to any type of diving, cliff diving, scuba diving etc, ask the following questions			X
23 g.2.2	Type of certification- Description	Indicate the types of certifications for diving			X
23 g.2.3	What is the Max Feet Depth Obtained?	Indicate the maximum feet obtained while diving			X
23 g.2.4	Do you Engage in Ice, Wreck, or Cave Diving?	Indicate Yes or No			X
23 g.2.5	Any other Remarks?	If yes indicate details			X
	Dive Purposes				X
23 g.2.6	What is the purpose of the dives?	Indicate the purpose of diving			X
23 g.2.7	What equipment is used?	Indicate the type of equipment used for diving			X
23 g.2.8	What is the location of the dives?	Indicate the locations of where the dives take place- city, state, zip code, or lake, ocean, etc...			X
	Dive Details				X
23 g.2.9	What has been your minimum Dive Depth?	Indicate the minimum dive depth			X
23 g.2.10	What has been your maximum Dive Depth?	Indicate the maximum dive depth			X
23 g.2.11	What was the number of dives in the last 12 Months?	Indicate the number of dives in the last 12 months			X

Life Application Data Elements

Application # Section	Field Name	Description of Field	Transfer from Quote	Required f	Comments section /overflow page
23 g 2.12	What will be the number of dives within the next 12 Months?	Indicate the number of dives in the next 12 months			X
23 g 2.13	What was the average Dive Minutes within the last year?	Indicate the average dive in minutes from last year			X
23 g 2.14	What will the average dive minutes be in the next year?	Indicate the average dive in minutes for next year			X
23 g 3	CLIMBING	If yes to any type of climbing ask the following questions			
23 g 3.1	Average degree of difficulty	Describe the average degree of difficulty for the climbs			X
23 g 3.2	Engage in technical climbing outside of North America	Describe if any climbs are outside North America			X
23 g 3.3	Climb Alone	Indicate if proposed insured climbs alone			X
23 g 3.4	Equipment used	Describe the equipment used for a climb			X
23 g 3.5	Average Climb Duration	Indicate the average climb duration			X
23 g 3.6	Average Climb Height	Indicate the average height for a climb			X
23 g 3.7	Maximum Climb Height	Indicate the maximum height of a climb			X
23 g 3.8	Number of Climbs past 12 months	Indicate the number of climbs performed within the past 12 months			X
23 g 3.9	Number of Climbs past 13-24 months	Indicate the number of climbs performed within the past 13-24 months			X
23 g 3.10	Number of Climbs next 12 months	Indicate the number of climbs that will be performed within the next 12 months			X
	Climbing Locations				X
23 g 3.11	Climbing Region	Indicate the location of the climbs, city, state, zip code.			X
	Climbing Terrain				X
23 g 3.12	Terrain Description	Indicate the type of the terrain when climbing			X
23 g 4	SKY DIVING	If yes to sky diving, ask the following drill down questions			
23 g 4.1	Certified	Indicate if proposed insured is certified to dive			X
23 g 4.2	Start Point Jump Description	Describe the starting point of the jump			X
23 g 4.3	Average Free Fall (feet)	Describe the average free fall in Feet			X
23 g 4.4	Maximum Free Fall (feet)	Describe the maximum free fall the proposed insured has performed			X
23 g 4.5	Maximum Duration (minutes)	Indicate the maximum duration of a fall from the proposed insured - minute format			X
23 g 4.6	Number of Jumps Past 12 Months	Indicate the number of jumps performed in the past 12 months			X
23 g 4.7	Number of Jumps Past 13-24 Months	Indicate the number of jumps performed in the last 13-24 months			X
23 g 4.8	Number of Jumps Next 12 Months	indicate the number of jumps planned for the next 12 months			X
23 g 5	OTHER HAZARDOUS ACTIVITIES				

Life Application Data Elements

Life Application Data Elements					
Application # Section	Field Name	Description of Field	Transfer from Quote	Required f	Comments section /overflow page
23 g 5.1	Activity Description	List other activities if they do not fall within one of the options above-			X
23 g 5.2	Certifications	List any certifications of the proposed insured from the listing activity above			X
23 g 5.3	Number of Activities Past 12 Months	Indicate the number of activities that the proposed insured performed within the last 12 months			X
23 g 5.4	Number of Activities Past 13-24 Months	Indicate the number of activities that the proposed insured performed within the last 13-24 months			X
23 g 5.5	Number of Activities Next 12 Months	Indicate the number of activities that the proposed insured will perform in the next 12 months			X
Foreign Travel					
23h	FOREIGN TRAVEL (in the last 2 years have you traveled outside of the US?)	Indicate Yes or No, If yes require the following drill down questions to be answered by the proposed insured		X	
23i	Country	List the country traveled to			X
23i	City List	List the city traveled to			X
23i	Year	Indicate the year traveled			X
23i	Length of stay (week, month, year)	Indicate the length of stay			X
23i	Purpose	Indicate the purpose of the travel			X
23j	In the next 2 years do you plan to travel outside of the US?	Indicate Yes or No, If yes require the following drill down questions to be answered by the proposed insured		X	
23 j 1	Travel Events	Indicate the travel events planned within the next two years			X
23 j 2	Country	List the country the proposed insured will travel to			X
23 j 3	City List	List the city the proposed insured will travel to			X
23 j 4	Year	Indicate the year when the event will occur			X
23 j 5	Length of stay (week, month, year)	Indicate the length of stay			X
23 j 6	Purpose	Indicate the purpose of the travel			X

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
Title 340-474	Header	Name of Insurance Company, address, city, state, zip	X	
	Policy Number	Number exactly as it appears on the policy	X	
	Logo	Sentry Life Insurance Logo	X	
Label	Life Insurance Application - Part 2 Medical History	Title of section	X	
Primary Care Provider				
24a	Medical Provider (name)	Provide the Physicians first and Last name	X	if more than one PCP, data appears here, if within the last year
24b	address	Provide the address of the health care facility that the Medical Provider is located at.	X	
24c	last visit	Date of last visit in MM/DD/YYYY	X	
24c	Reason Last Seen	Indicate the reason you last saw this Primary care Provider.	X	
24c	Diagnosis/Treatment provided (result of visit)	Describe the symptoms an diagnosis if know.	X	
24 c 1	Comments	Provide any additional information not captured above		X- free form
General Health Information				
24d	Height	Provide the height of the proposed insured in feet and inches	X	
24d	Weight	Provide the weight of the proposed insured	X	
24d	Weight loss in the last 12 months	Indicate the amount of weight lost within the last 12 months	X	
24e	Are you currently pregnant?	Indicate Yes or No if the proposed insured is pregnant		females only
24e	Due date?	Indicate the due date of pregnancy using MM/DD/YYYY format		
24e	Pre-pregnancy weight?	Indicate the proposed insured pre-pregnancy weight		
24e	have you ever had any of the following complications or problems with current or past pregnancies: gestational diabetes, toxemia/high blood pressure, cesarean section, placenta previa, premature labor or ectopic pregnancy?	If Yes, indicate which problem with current or past pregnancies		
Drug and Alcohol Use/Treatment				
24f	NICOTINE (Have you in the last 3 years used any form of tobacco, nicotine or nicotine replacement therapy (including cigarette, cigar, pipe, chewing tobacco, Nicorette gum, E-cig, nicotine patch, or nicotine nasal spray?)	Indicate Yes or No, if Yes, drop down questions are required to be answered	X	

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24f	Type	Indicate the type of nicotine used from the list above or other		
24 f 1	Quantity (number used)	Indicate the quantity of the Nicotine that the proposed insured uses		X
24 f 2	Frequency	Indicate the frequency (daily, weekly, monthly) of the use of nicotine the proposed insured uses		X
24 f 3	Length of Use	Indicate the length of use for the nicotine- still currently using, quit for a period of time, or haven't since (year, date)		X
	DRUGS			
24g	Other than as prescribed by a physician, have you used Cocaine, Heroin, Morphine, LSD, Marijuana, PCP, or any other hallucinogenic or narcotic drug during the past 10 years	Indicate Yes or No, If Yes, drop down questions are required to be answered by the proposed insured	X	
	Drugs Used			
24g	Name of drug	Indicate the drug name		X
24 g 1	Form of how the drug is used (pills, injections, powder, smoke etc.)	Describe how the drug is/was used- by pills, powder, smoke, etc.		X
24 g 2	Frequency	Indicate the frequency (daily, weekly, monthly) of the use of the drug		X
24 g 3	Amount	Indicate the amount used when taken		X
24 g 4	Length of Use	Indicate the length of use for the drug- still currently using, one year, one month etc		X
24 g 5	Date last Used	Indicate the date the drug was last used- use format of MM/DD/YYYY		X
24 g 6	How long have you totally abstained from drugs?	Indicate timeframe- hours, days, weeks, months, years		X
24 g 7	Have you had any relapses since the first date of abstaining?	Indicate Yes or No, if Yes, ask the next drop down question		X
24 g 8	Date	Indicate the date of the relapse in MM/DD/YYYY format		X
24 g 9	Have you ever had charges filed against you for the illegal possession, usage, or distribution of drugs?	Indicate Yes or No, If yes, ask the following drop down questions		X
24 g 10	Dates	Indicate the dates using MM/DD/YYYY format of the charges		X
24 g 11	Charges	Indicate the actual charges that were filed		X
24 g 12	Country of Occurrence	Indicate the country that the charge was filed		X

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24 g 13	State of Occurrence	Indicate the state that the charge was filed		X
24 g 14	Sentence	Indicate the sentence that was given based on the charges filed		X
24 g 15	Currently on Parole or Probation?	Indicate Yes or No, If yes, ask probation end date		X
24 g 16	Probation End Date	Indicate end date of probation in MM/DD/YYYY format		X
24 g 17	Are you now or have you ever been a member of a support group such as Narcotics Anonymous?	Indicate Yes or No, if Yes ask the following drop down questions		X
24 g 18	Dates (start date, end date)	Indicate the dates belonging to a support group		X
24 g 19	Currently a member	Indicate the name of the support group the proposed insured belongs to		X
24 g 20	Have you received treatment for drug use?	Indicate Yes or No, if Yes ask the following drop down questions		X
24 g 21	Dates	Indicate the dates of drug treatment- MM/DD/YYYY format		X
24 g 22	inpatient/outpatient	Indicate if treated for drug use was it an inpatient or outpatient visit		X
24 g 23	Duration	Indicate the duration of the visit		X
24 g 24	Treating Medical Provider	Provide Doctor's specialty, doctors name, name of facility, address of facility, phone number of facility and date last seen at facility.		X
	ALCOHOL			
24h	Do you presently use alcoholic beverages?	Indicate Yes or No, if Yes, ask the following 2 questions	X	
24 h 1	Number/Frequency	Indicate by number or frequency the amount of beverages consumed		
24h	Type	Indicate the type of alcohol consumed (hard liquor, beer, wine)		
24 h 2	Did you ever drink substantially more than at present?	Indicate Yes or No, if Yes ask all of the following drop down questions, if NO, do not ask any more of the following questions	X	X

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24 h 3	Number/Frequency	Indicate by number or frequency the amount of beverages consumed		X
24 h 4	Type	Indicate the type of alcohol consumed (hard liquor, beer, wine)		X
24 h 5	Are you now or have you ever been a member of a support group such as Alcoholics Anonymous?	Indicate Yes or No, if Yes ask the following drop down questions		X
24 h 6	Dates (start date, end date)	Indicate the dates belonging to a support group		X
24 h 7	Currently a member?	Indicate the name of the support group the proposed insured belongs to		X
24 h 8	Have you received treatment for alcohol use?	Indicate Yes or No, if Yes ask the following drop down questions (24h9-15)		X
24 h 9	Dates	Indicate the dates of alcohol treatment- MM/DD/YYYY format		X
24 h 10	Inpatient/outpatient	Indicate when treated for alcohol use was it an inpatient or outpatient visit		X
24 h 11	Duration	Indicate the duration of the visit		X
24 h 12	Treating Medical Provider	(See data definitions tab)		X
24 h 13	How long have you totally abstained from alcohol?	Indicate Yes or No		X
24 h 14	Have you had any relapses since the first date of abstaining?	Indicate Yes or No, If Yes, ask for dates.		X
24 h 15	Dates	Indicate the dates of any relapse		X
Medical Conditions				
<i>24. Have you ever been diagnosed, treated, tested positive for, or been given medical advice by a member of the medical profession for:</i>				
1	Any disorder or disease of the brain, nervous system or mental disorder;			
24.1	SEIZURE DISORDER	If Yes ask the following drop down questions	X	
24.1 a	Date of original episode or diagnosis	Indicate date in MM/DD/YYYY format		X
24.1 b	Date of last episode	Indicate date in MM/DD/YYYY format of last episode		X
24.1 c	Type of seizure:	Select which type(from the following list) of epilepsy		X
24.1 d	Tonic-clonic Seizure (Grand Mal)			X
24.1 e	Absence Seizure (Petit Mal)			X
24.1 f	Complex Partial Seizure			X
24.1 g	Simple Seizure (Jacksonian)			X
24.1 h	Other	If Other is selected description is required		X
24.1 i	Description	Describe the "other" type		X

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24.1 j	Number of episodes or seizures in the past 12 months	Within the last 12 months indicate count of seizures/episodes		X
24.1 k	Number of episodes or seizures in the past 13-24 months	Within the last 13-24 months indicate count of seizures/episodes		X
24.1 l	Medications taken	(See data definitions tab)		X
24.1 m	Has the type of medication or dosage changed in the past year? If yes, explain	If yes, enter comments into blank drop down section		X
24.1 n	Ever hospitalized for this condition?	If yes, ask the hospitalized condition questions on the data definitions tab		X
24.1 o	Treating Medical Provider	(See data definitions tab)		X
24.1.2	Traumatic Brain Injury	If yes, ask the 5 D questions on the data definitions tab -	X	
24.1.2 a	Record the 5 D's	(See data definitions tab)		X
24.1.3	Parkinson's Disease	If yes, ask the 5 D questions on the data definitions tab -	X	
24.1.3 a	Record the 5 D's	(See data definitions tab)		X
24.1.4	DEPRESSION, NERVOUS OR MENTAL DISORDERS	If yes, as the following drop down questions	X	
24.1.4 a	Date of original diagnosis?	Indicate date in MM/DD/YYYY format		X
24.1.4 b	Date of last symptoms?	Indicate the date of the last symptom in MM/DD/YYYY format		X
24.1.4 c	Specific diagnosis?	Describe the specific diagnosis given by the Physician		X
24.1.4 d	Medications taken	(See data definitions tab)		X
24.1.4 e	Ever hospitalized for this psychiatric condition?	(See data definitions tab)		X
24.1.4 f	Treating Medical Provider	(See data definitions tab)		X
24.1.4 g	Ever received Shock Therapy?	Indicate Yes or No		X
24.1.4 h	Is there any history of the following?	Select which type (from the drop down list below)		
24.1.4 i	Type			
	Substance abuse			X
	Personality disorder			X
	Psychotic disorder			X
	Suicidal thoughts or disorder			X
24.1.4 j	Detail	Explain the details of the type selected above		X
24.1.4 k	Date	Indicate the date of the type selected above in MM/DD/YYYY format		X
24.1.4 l	Loss of time from work or usual daily activities?	Describe if time away from work or unable to perform daily activities (which activities) based on the type selected above		X

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24.1.4 m	Date (start date/end date)	Indicate the dates in MM/DD/YYYY format of loss of work or unable to perform daily activity		X
24.1.4 n	Length of Time	Indicate the length of time of loss of work or unable to perform daily activities (days, weeks, months, year?)		X
24.1.5	MIGRAINES			
24.1.5 a	Record the 5 D's	(See data definitions tab)		X
24.1.6	MULTIPLE SCLEROSIS			
	Record the 5 D's	(See data definitions tab)		X
24.2 Any disorder or disease of the respiratory system;				
24.2	EMPHYSEMA OR COPD	If yes, as the following drop down questions	X	
24.2 a	Record the 5 D's	(See data definitions tab)		X
24.2 b	last pulmonary function test (date)	Indicate date of last test in MM/DD/YYYY format		X
24.2.1	SARCOIDOSIS	If yes, as the following drop down questions	X	
24.2.1 a	Record the 5 D's	(See data definitions tab)		X
24.2.2	TUBERCULOSIS	If yes, as the following drop down questions	X	
24.2.2 a	Record the 5 D's	(See data definitions tab)		X
24.2.3	ASTHMA	If yes, as the following drop down questions	X	
24.2.3 a	Date of last attack	Indicate date of last attack in MM/DD/YYYY format		X
24.2.3 b	last pulmonary function test (date)	Indicate date of last pulmonary test in MM/DD/YYYY		X
24.2.3 c	Intensity:	Indicate the type of intensity of the asthma by selecting one of the options below		
	MILD - no work time lost, lungs clear between attacks			X
	MODERATE-Acute attacks treated by injection or spray of adrenaline or ephedrine. There may be slightly wheezy breathing or a few musical rales. Chronic asthma with no work time lost and no emphysema.			X
	SEVERE-Attacks treated by admission to a hospital or change of climate on account of asthma. Mild or moderate emphysema may be present.			X
24.2.3 d	Frequency:	Indicate the Frequency of asthma by selecting one of the options below		
	OCCASIONAL-Seasonal or not over six attacks per year			X
	FREQUENT-More than six attacks per year or chronic			X
24.2.3 e	Is there a history of status asthmaticus?	Indicate Yes or No, if Yes ask the following drop down questions		X
24.2.3 f	Number of attacks	Indicate the number of attacks		X

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24.2.3 g	Date of last attack	Indicate the date of the last attack in MM/DD/YYYY format		X
24.2.3 h	Have you had episodes of spitting of blood?	Indicate Yes or No, if Yes ask the following drop down questions		X
24.2.3 i	Cause	Indicate the cause of spitting of blood		X
24.2.3 j	Date of episode	Indicate the date this episode occurred in MM/DD/YYYY format		X
24.2.3 k	Medications taken	(See data definitions tab)		X
24.2.3 l	Ever hospitalized for this condition?	(See data definitions tab)		X
24.2.3 m	Treating Medical Provider	(See data definitions tab)		X
24.2.4	Sleep Apnea	If yes, ask the following drop down questions	X	
24.2.4 a	Date of last sleep study	Indicate the date in MM/DD/YYYY for last sleep study		
24.2.4 c	Record the 5 D's	(See data definitions tab)		X
24.2.5	OTHER LUNG DISEASE OR DISORDERS	If yes, ask the following drop down questions	X	
24.2.5 a	Record the 5 D's	(See data definitions tab)		X
24.3 Any disorder or disease of the heart, blood vessels or circulatory system;				
24.3.1	HIGH BLOOD PRESSURE	If yes, ask the following drop down questions	X	
24.3.1 a	Record the 5 D's	(See data definitions tab)		X
24.3.2	ANGINA	If yes, ask the following drop down questions	X	
24.3.2 a	Date of original diagnosis?	Indicate the date of the original diagnosis of chest pain in MM/DD/YYYY format		X
24.3.2 b	Date of last symptoms?	Indicate the date of the last symptom in MM/DD/YYYY format		X
24.3.2 c	Specific diagnosis?	Describe the specific diagnosis given by the Physician		X
24.3.2 d	Were EKGs and/or Exercise Stress tests completed?	Indicate EKG or Stress test or None		X
24.3.2 e	Results	If yes to EKG or Stress Test indicate the results of those tests		X
24.3.2 f	Medications taken	(See data definitions tab)		X
24.3.2 g	Ever hospitalized for this condition?	(See data definitions tab)		X
24.3.2 h	Treating Medical Provider	(See data definitions tab)		X
24.3.3	HEART MURMUR	If yes, ask the following drop down questions	X	
24.3.3 a	Date of original diagnosis?	Indicate the date of the original diagnosis of chest pain in MM/DD/YYYY format		X

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24.3.3 b	Specific type or diagnosis of heart murmur:	Indicate specific type or diagnosis of the heart murmur from the type selection below		X
	Aortic Insufficiency			X
	Aortic Stenosis			X
	Atrial Septal Defect			X
	Mitral Valve Prolapse			X
	Mitral Insufficiency (Mitral regurgitation)			X
	Mitral Stenosis			X
	Ventricular Septal Defect			X
	Other	If Other is selected description is required		X
24.3.3 c	Description	Describe the diagnosis		X
	Have you ever had or been diagnosed with:			X
24.3.3 d	Subacute bacterial endocarditis	Indicate Yes or No		X
24.3.3 e	Arrhythmias (irregular heart beats or rhythm)	Indicate Yes or No		X
24.3.3 f	Syncope (dizziness, fainting, or loss of consciousness)	Indicate yes or No		X
24.3.3 g	Emboli (blood clot)	Indicate yes or No		X
24.3.3 h	Congestive heart failure	Indicate yes or No		X
24.3.3 i	Have you had Echocardiograms?	Indicate yes or No, If yes complete dates field		X
24.3.3 i	Dates	Indicate the dates in MM/DD/YYYY format		X
24.3.3 j	Was surgery or heart valve replacement completed or recommended?	Indicate Yes or No, if yes complete details field		X
24.3.3 j	Details	Describe the surgery		X
24.3.3 k	Treating Medical Provider	(See data definitions tab)		X
24.3.4	RHEUMATIC FEVER	If yes, ask the following drop down questions	X	
24.3.4 a	Record the 5 D's	(See data definitions tab)		X
24.3.5	STROKE (Cerebrovascular Attack- CVA) or (Transient Ischemic Attack- TIA)	If yes, ask the following drop down questions	X	
24.3.5 a	Record the 5 D's	(See data definitions tab)		X
24.3.6	HEART ATTACK (MI- Myocardial Infarction)	If yes, ask the following drop down questions	X	
24.3.6 a	Date of original diagnosis?	Indicate the date of the original diagnosis of chest pain in MM/DD/YYYY format		X
24.3.6 b	Date of last symptoms?	Indicate the date of the last symptom in MM/DD/YYYY format		X
24.3.6 c	Specific diagnosis?	Describe the specific diagnosis given by the Physician		X
24.3.6 d	Were EKGs and/or Exercise Stress tests completed?	Indicate EKG or Stress test or None		X
24.3.6 e	Results	If yes to EKG or Stress Test indicate the results of those tests		X
24.3.6 f	Medications taken	(See data definitions tab)		X
24.3.6 g	Ever hospitalized for this condition?	(See data definitions tab)		X
24.3.6 h	Treating Medical Provider	(See data definitions tab)		X

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24.3.7	OTHER HEART , BLOOD VESSEL OR CIRCULATORY DISEASE OR DISORDER	If yes, ask the following drop down questions	X	
24.3.7 a	Record the 5 D's	(See data definitions tab)		X
24.4 Any disorder or disease of the stomach, liver, intestines, rectum, pancreas or abdominal organs;				
24.4	Gastrointestinal Bleed	If yes, ask the following drop down questions	X	
24.4 a	Date of original diagnosis?	Indicate the date of the original diagnosis of chest pain in MM/DD/YYYY format		X
24.4 b	Date of last symptoms?	Indicate the date of the last symptom in MM/DD/YYYY format		X
24.4 c	Specific diagnosis:	Select from the list which diagnosis		X
	Colitis			X
	Irritable Bowel Syndrome			X
	Crohns Disease			X
	Ulcerative Colitis			X
	Ulcerative Proctitis			X
	Chronic Diarrhea			X
24.4 c 1	Other	If Other is selected description is required		X
24.4 c 2	Description	Describe the diagnosis		X
24.4 d	Number of attacks per year	Indicate the number of attacks per year		X
24.4 e	Date of last colonoscopy	Indicate date in MM/DD/YYYY format		X
24.4 f	Date of last EGD	Indicate date in MM/DD/YYYY format		X
24.4 g	Treatment details	Indicate details of treatment received		X
24.4 h	Has surgery been completed or contemplated?	Indicate Yes or No		X
24.4 i	Medications taken	(See data definitions tab)		X
24.4 j	Treating Medical Provider	(See data definitions tab)		X
24.4.1	ULCER	If yes, ask the following drop down questions	X	
24.4.1 a	Date of original diagnosis?	Indicate the date of the original diagnosis of chest pain in MM/DD/YYYY format		X
24.4.1 b	Date of last symptoms?	Indicate the date of the last symptom in MM/DD/YYYY format		X
24.4.1 c	Specific diagnosis?	Describe the specific diagnosis given by the Physician		X
24.4.1 d	Number of attacks per year	Indicate the number of attacks per year		X
	When was your Last upper GI (gastrointestinal) exam?			X
24.4.1 e	Date	Indicate date in MM/DD/YYYY format		X
24.4.1 e	Results	Indicate the results of the exam		X

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24.4.1 f	Was there perforation or bleeding associated with the ulcer?	Indicate Yes or No, if Yes ask the following drop down questions		X
24.4.1 g	Treatment details	Indicate details of treatment received		X
24.4.1 h	Has surgery been completed or contemplated?	Indicate Yes or No		X
24.4.1 i	Treating Medical Provider	(See data definitions tab)		X
24.4.2	GASTROINTESTINAL REFLUX DISEASE (GERD)	If yes, ask the following drop down questions	X	
24.4.2 a	Record the 5 D's	(See data definitions tab)		X
24.4.3	INTESTINAL DISORDER	If yes, ask the following drop down questions	X	
24.4.3 a	Date of original diagnosis?	Indicate the date of the original diagnosis of chest pain in MM/DD/YYYY format		X
24.4.3 b	Date of last symptoms?	Indicate the date of the last symptom in MM/DD/YYYY format		X
24.4.3 c	Specific diagnosis:	Select from the list which diagnosis		X
	Diverticulitis			X
	Diverticulosis			X
24.4.3 c 1	Other	If Other is selected description is required		X
24.4.3 c1	Description	Describe the diagnosis		X
	Occurrences?			X
24.4.3 d	Date	Indicate the date in MM/DD/YYYY format		X
24.4.3 d1	Duration	Indicate the duration of the occurrences		X
24.4.3 d2	Symptoms	Describe the symptoms		X
24.4.3 e	What is the current condition	Describe the current status of the condition		X
24.4.3 f	Has surgery been completed or contemplated?	Indicate yes or no		X
24.4.3 g	Medications taken	(See data definitions tab)		X
24.4.3 h	Ever hospitalized for this condition?	(See data definitions tab)		X
24.4.3 i	Treating Medical Provider	(See data definitions tab)		X
24.4.4	PANCREAS DISEASE	If yes, ask the following drop down questions	X	
24.4.4 a	Record the 5 D's	(See data definitions tab)		X
24.4.5	LIVER DISEASE OR DISORDER	If yes, ask the following drop down questions	X	
24.4.5 a	Record the 5 D's	(See data definitions tab)		X
24.4.5 b	Did you have a Liver Biopsy?	Indicate Yes or No, if Yes ask the following drop down questions		X
24.4.5 b1	Date	Indicate the date in MM/DD/YYYY format		X
24.4.5 b2	Results	Indicate the results of the biopsy		X

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24.4.6	OTHER DISEASE OR DISORDERS	If yes, ask the following drop down questions	X	
24.4.6 a	Record the 5 D's			
24.5 Any disorder or disease of the genito-urinary organs;				
24.5	KIDNEY STONE	If yes, ask the following drop down questions	X	
24.5 a	Date of original diagnosis?	Indicate the date of the original diagnosis of chest pain in MM/DD/YYYY format		X
24.5 b	Date of last symptoms?	Indicate the date of the last symptom in MM/DD/YYYY format		X
24.5 c	Number of episodes	Indicate the number of eipisodes		X
24.5 d	Removed by surgical intervention?	Indicate Yes or No		X
24.5 e	Stones present at this time?	Indicate Yes or No		X
24.5 f	Medications taken	(See data definitions tab)		X
24.5 g	Ever hospitalized for this condition?	(See data definitions tab)		X
24.5 h	Treating Medical Provider	(See data definitions tab)		X
24.5.1	KIDNEY DISEASE	If yes, ask the following drop down questions	X	
24.5.1 a	Date of original diagnosis?	Indicate the date of the original diagnosis of chest pain in MM/DD/YYYY format		X
24.5.1 b	Date of last episode?	Indicate the date of the last symptom in MM/DD/YYYY format		X
24.5.1 c	Number of episodes?	Indicate the number of eipisodes		X
24.5.1 d	Specific diagnosis:	Select from the list which diagnosis		X
	Nephritis			X
	Renal Aneurysm			X
	Renal Artery Stenosis			X
	Renal Cysts			X
	Renal Failure			X
24.5.1 e	Other	If Other is selected description is required		X
24.5.1 f	Description	Describe the diagnosis		X
24.5.1 g	Medications taken	(See data definitions tab)		X
24.5.1 h	Ever hospitalized for this condition?	(See data definitions tab)		X
24.5.1 i	Treating Medical Provider	(See data definitions tab)		X
24.5.2	BLADDER DISEASE	If yes, ask the following drop down questions	X	
24.5.2 a	Record the 5 D's	(See data definitions tab)		X
24.5.3	PROSTATE DISEASE	If yes, ask the following drop down questions	X	
24.5.3 a	Record the 5 D's	(See data definitions tab)		X
24.5.3 b	When was your Last PSA (Prostatic Specific Antigen) test?			X
24.5.3 b1	Date	Indicate the date of test in MM/DD/YYYY format		X

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24.5.3 b2	Results	Indicate the results of the exam		X
24.5.4	GLYCOSURIA (SUGAR IN THE URINE)	If yes, ask the following drop down questions	X	
24.5.4 a	Record the 5 D's	(See data definitions tab)		X
24.5.5	HEMATURIA (BLOOD IN THE URINE)	If yes, ask the following drop down questions	X	
24.5.5 a	Record the 5 D's	(See data definitions tab)		X
24.5.6	PROTEINURIA (ALBUMIN OR PROTEIN IN THE URINE)	If yes, ask the following drop down questions	X	
24.5.6 a	Record the 5 D's	(See data definitions tab)		X
24.5.7	OTHER URINARY TRACT DISORDER	If yes, ask the following drop down questions	X	
24.5.7 a	Record the 5 D's	(See data definitions tab)		X
24.6 Any disorder or disease of the blood, thyroid, or endocrine system;				
24.6	DIABETES	If yes, ask the following drop down questions	X	
24.6 a	Record the 5 D's	(See data definitions tab)		X
24.6.1	THYROID DISEASE OR DISORDER	If yes, ask the following drop down questions	X	
24.6.1 a	Date of original diagnosis?	Indicate the date of the original diagnosis of chest pain in MM/DD/YYYY format		X
24.6.1 b	Date of last symptoms?	Indicate the date of the last symptom in MM/DD/YYYY format		X
24.6.1 c	Specific diagnosis:	Select from the list which diagnosis		X
	Hypothyroid			X
	Hyperthyroid			X
	Thyroiditis (Hashimoto's Disease)			X
	Thyroid Enlargement (Goiter)			X
24.6.1 c1	Other	If Other is selected description is required		X
24.6.1 c2	Description	Describe the diagnosis		X
24.6.1 c3	Medications taken	(See data definitions tab)		X
24.6.1 c4	Ever hospitalized for this condition?	(See data definitions tab)		X
24.6.1 c5	Treating Medical Provider	(See data definitions tab)		X
24.6.2	OTHER ENDOCRINE DISORDERS	If yes, ask the following drop down questions	X	
24.6.2 a	Record the 5 D's	(See data definitions tab)		X
24.7 Any cancer, tumor, cyst or disorder of the skin or lymph glands;				
24.7	CANCER, TUMOR OR CYST	If yes, ask the following drop down questions	X	
24.7 a	Date of original diagnosis?	Indicate the date of the original diagnosis of chest pain in MM/DD/YYYY format		X
24.7 b	Specific diagnosis?	Indicate the date of the last symptom in MM/DD/YYYY format		X

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24.7 c	Do you know the Stage or Grade from the pathology report?	Indicate Yes or No, if yes, list the stage or grade		X
24.7 d	Was treatment received?	Indicate Yes or No, if Yes ask the following drop down questions		X
24.7 e	Type of treatment:			X
	Excision			X
	Radiation			X
	Chemotherapy			X
	Observation			X
	Other	If Other is selected description is required		X
24.7 e1	Description	Describe the treatment		X
24.7 f	Date of the last treatment?	Indicate the date of last treatment in MM/DD/YYYY format		X
24.7 g	Were any follow-up tests or procedures recommended?	Describe any additional tests or procedures suggested by the Physican		X
24.7 h	Medications taken	(See data definitions tab)		X
24.7 i	Ever hospitalized for this condition?	(See data definitions tab)		X
24.7 j	Treating Medical Provider	(See data definitions tab)		X
24.7.1	SKIN DISORDER	If yes, ask the following drop down questions	X	
24.7.1 a	Record the 5 D's	(See data definitions tab)		X
24.7.2	LYMPH GLAND DISORDER	If yes, ask the following drop down questions	X	
24.7.2 a	Record the 5 D's	(See data definitions tab)		X
24.8 Any disorder or disease of the skeletal system or immune system other than HIV;				
24.8	NEURITIS, FIBROMYALGIA or LUPUS	If yes, ask the following drop down questions	X	
24.8 a	Record the 5 D's	(See data definitions tab)		X
24.8.1	ARTHRITIS	If yes, ask the following drop down questions	X	
24.8.1 a	Date of original diagnosis?	Indicate the date of the original diagnosis of chest pain in MM/DD/YYYY format		X
24.8.1 b	Date of last symptoms?	Indicate the date of the last symptom in MM/DD/YYYY format		X
24.8.1 c	Specific diagnosis:	Select from the list which diagnosis		X
	Rheumatoid			X
	Osteoarthritis			X
	Gout			X
	Ankylosing Spondylitis			X
	Reiters Syndrome			X
24.8.1 d1	Other	If Other is selected description is required		X
24.8.1 d2	Description	Describe the treatment		X
24.8.1 e	Is there any organ involvement?	Indicate Yes or No		X

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24.8.1 f	Please explain any difficulty completing activities of daily living	Describe daily activities that are difficult to complete		X
24.8.1 g	Please list any treatments	Indicate any treatments suggested by the Physician		X
24.8.1 h	Medications taken	(See data definitions tab)		X
24.8.1 i	Ever hospitalized for this condition?	(See data definitions tab)		X
24.8.1 j	Treating Medical Provider	(See data definitions tab)		X
24.8.2	DISORDER OF THE MUSCLES	If yes, ask the following drop down questions	X	
24.8.2 a	Record the 5 D's	(See data definitions tab)		X
24.8.3	DISORDER OF THE BONES	If yes, ask the following drop down questions	X	
24.8.3 a	Record the 5 D's	(See data definitions tab)		X
24.8.4	DISORDER OF THE JOINTS	If yes, ask the following drop down questions	X	
24.8.4 a	Record the 5 D's	(See data definitions tab)		X
24.8.5	OTHER DISORDERS OF THE IMMUNE SYSTEM	If yes, ask the following drop down questions	X	
24.8.5 a	Record the 5 D's	(See data definitions tab)		X
24.9 Acquired Immune Deficiency Syndrome (AIDS) or Human Immunodeficiency Virus (HIV).				
24.9	HIV (Human Immunodeficiency Virus)	If yes, ask the following drop down	X	
24.9 a	Record the 5 D's	(See data definitions tab)		X
24.9.1	AIDS (Acquired Immune Deficiency Syndrome)	If yes, ask the following drop down questions	X	
24.9.1 a	Record the 5 D's	(See data definitions tab)		X
Other Medical Questions				
<i>Other than already mentioned, have you:</i>				
24.10	Been a patient in a hospital, sanitarium, or other medical institution?	Indicate Yes or No, If yes ask the 5 D's	X	
24.10 a	Record the 5 D's	(See data definitions tab)		X
24.11	Been treated for a condition or taken medications?	Indicate Yes or No, If yes ask the 5 D's	X	
24.11 a	Record the 5 D's	(See data definitions tab)		X
24.12	Advised to have a surgery or medical test?	Indicate Yes or No, If yes ask the 5 D's	X	
24.12 a	Record the 5 D's	(See data definitions tab)		X
24.13	Consulted a physician, psychiatrist, or other practitioner?	Indicate Yes or No, If yes ask the 5 D's	X	
24.13 a	Record the 5 D's	(See data definitions tab)		X
24.14	Ever received WC/SS/Disability or other Disability Payments?	Indicate Yes or No, If yes ask the 5 D's	X	
24.14 a	Record the 5 D's	(See data definitions tab)		X
Biological Family Census				
24.15	Have you had a parent or sibling diagnosed or treated by a member of the medical profession for the following conditions: Heart, cerebrovascular disease, cancer or diabetes?	Indicate yes or no, If yes, complete family member questions that will appear in the table grid	X	
<i>Please list the following for your immediate family members (biological parents and siblings):</i>				
24.15	Relationship (mother, father, brother, sister)	Indicate each member of the immediate family	X	
24.15	Age At Death	Indicate age at death	X	

Life Application Data Elements				
Application Section	Field Name	Field and or section description	Required	Comments section
24.15	Age If Living	Indicate current age if still living	X	
24.15	Cause of Death	Indicate cause of death	X	
24.15	Condition/Diagnosis (Heart Disease, Stroke, Cancer or Diabetes)	Indicate which condition/diagnosis from selection	X	
24.15	Age at onset of condition	Indicate the age when condition was diagnosed	X	
Title 340-474	Header	Name of Insurance Company, address, city, state, zip	X	
	Policy Number	Number exactly as it appears on the policy	X	
	Logo	Sentry Life Insurance Logo	X	
Payment Mode		The proposed insured payment mode selection of Monthly, Quarterly, Annually or Semi-annually would appear		
Initial Premium paid		Dollar amount the insured/owner/payor paid down on the application	X	
Signatures	Proposed Insured	Proposed Insured must sign form by wet signature or voice signature	X	
	Dated At, Date	city and state of where application was presented and date application was voice or wet signed		
	Owner	Owner must sign form by wet signature or voice signature	X	
	Payor	Payor must sign form by wet signature or voice signature	X	
	Writing Agent	Signature of writing agent- wet signature or voice signature	X	
	Producer ID	Producer ID from Agency Management system of the writing sales agent	X	

Record the Five D's				
Diagnoses	describe the diagnosis			
Dates	Indicate the dates in MM/DD/YYYY format			
Drugs	Use the "Medications taken" drop down questions			
Doctors	Use the "Treating Medical Provider" drop down questions			
Duration	Describe the duration of the illness			
Medications taken				
Drug Name	List the name of the drug			
Frequency	List the frequency of the drug			
Dosage	Indicate dosage amount			
Hospitalized for condition				
Date	Indicate the date the proposed insured was hospitalized in			
Hospital	Indicate the name of the hospital where the proposed insured			
Treatment	Indicate the treatment received for this hospitalization			
inpatient/outpatient	Indicate if this was an inpatient or outpatient hospital stay			
Treating Medical Provider				
Specialty	Indicate the type of specialty the doctor is			
First Name	Provide the physician's first name			
Last Name	Provide the physician's last name			
Facility Name	Indicate the name of the facility of the doctor			
Address Line 1	Indicate the address of the facility of the doctor			
Address Line 2	Indicate the address of the facility of the doctor			
City	Indicate the city of the facility of the doctor			
State	Indicate the state of the facility of the doctor			
Zip	Indicate the zip of the facility of the doctor			
Phone	Indicate the phone number of the doctor/facility			
Date Last Seen	Indicate the date last seen in MM/DD/YYYY format			

Sentry Life Insurance Company

1800 North Point Drive
Stevens Point, WI 54481
1-800-533-7827



SENTRY[®]
LIFE INSURANCE
COMPANY

AGENT'S REPLACEMENT REPORT
(Must be completed and submitted with the application in the event of replacement)

The following company approved printed and electronic sales material was presented to the applicant: (provide form number and print date or title, if no form number):

All sales material listed above was left with the applicant. In addition, any individualized sales material and any illustration prepared for the applicant, have been left with the applicant and copies have been sent to Sentry with this application.

Agent's Signature

Date

340-351



1085333



340-351

4/07(v)

DOC SCAN



SENTRY®
INSURANCE

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) TESTING

Insurer: Sentry Life Insurance Company

Address: 1800 North Point Drive, Stevens Point, WI 54481

To evaluate your eligibility for insurance or insurance benefits, it is requested that you consent to be tested for the AIDS virus (HIV). By signing and dating this form, you agree that this test may be performed and that underwriting decisions will be based on the test results.

DISCLOSURE OF TEST RESULTS

All test results will be treated confidentially. The results of the test will be reported to the insurer identified on this form. Results of the tests will not otherwise be disclosed except as allowed by law or as stated below.

MEANING OF TEST RESULTS

While positive HIV antibody test results do not mean that you have AIDS, they do mean that you may be at increased risk of developing AIDS or AIDS-related conditions. The test is a test for antibodies of the HIV virus the causative agent for AIDS, and shows whether you have been exposed to the virus.

Positive HIV antibody test results could adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

RELEASE OF RESULTS:

The results of this test may be released to the following:

1. the proposed insured;
2. the person legally authorized to consent to the test;
3. a licensed physician, medical practitioner, or other person designated by the proposed insured;
4. an insurance medical information exchange under procedures that are designed to assure confidentiality, including the use of general codes that also cover results of tests for other diseases or conditions not related to AIDS, or for the preparation of statistical reports that do not disclose the identity of any particular proposed insured;
5. a reinsurer, if the reinsurer is involved in the underwriting process, under procedures that are designed to assure confidentiality;
6. persons who have the responsibility to make underwriting decisions on behalf of the insurer; or
7. insurer's legal counsel who needs such information to effectively represent the insurer in regard to matters concerning the proposed insured.

The insurer may contact you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may want to discuss the results.

CONSENT:

I have read and I understand this Notice and Consent Form. I voluntarily consent to testing and disclosure as described above. I understand that I have the right to request and receive a copy of this form. A photocopy of this form will be as valid as the original.

Date:

Signature of Proposed Insured or
Parent/Guardian

In the event of a positive test result, I authorize Sentry Life Insurance Company to send the result to the following physician:

Physician's Name (Please Print)

Address (Please Print)

You may also designate an individual other than a physician who you wish to be notified of a positive test result.

Name (Please Print)

Address (Please Print)