Sentinel Security Life

Sentinel Security Life Insurance Company

The Sentinel Plan® New Vantage® I, II, III

- Helps Cover Final Expenses
- First Day Coverage Available
- Guaranteed Coverage For Life
  (as long as premiums are paid on time)
- Premiums Can Never Be Increased
- Whole Life Benefits Never Go Down
- Coverage Cannot Be Canceled
  (as long as premiums are paid on time)
- Builds Cash and Loan Values

SENTINEL SECURITY LIFE INSURANCE COMPANY
PO BOX 65478 SALT LAKE CITY, UTAH 84165
STATE OF DOMICILE: UTAH

Important Reminders

- New Vantage® plans use the "age last birthday" method for determining the age of the proposed insured for insurance purposes. Premium quote calculations should be based upon the proposed insured's issue age (i.e. actual age) on the policy issue date. If a specific (delayed) policy issue date is requested, ensure that the premium submitted is based upon the correct issue age.
- The policy's issue date will be the date that Sentinel Security Life approves the application, unless a preferred issue date is requested in the application. A preferred issue date, for ACP draw purposes, should be indicated by designating a specific ACP draft date in Section 11 (Automatic Check, Debit/Credit Card Plan Authorization) of the application. If the first premium payment is being made by ACP, Sentinel Security Life will draw the first premium the day the application is received unless a preferred issue date is requested. A preferred issue date, to save insurance age, should be indicated in the Agent Notes area of Section 13.
- If a specific draft date is requested, the policy issue date will be the first time that date occurs after the date that Sentinel Security Life receives the application. For example, if the specific draft date requested is the 15th day of the month, and the application is dated January 12th but arrives at Sentinel Security Life Home Office on January 16th, the policy issue date, if approved, would be February 15th.
    - There is **NO** temporary insurance coverage in effect. Ensure that the owner is aware of this.
- In some cases the New Vantage® policy that is issued may differ in policy type and/or insurance amount from what was selected in the application:
    - If the proposed insured does not qualify for the policy type selected, Sentinel Security Life may issue a different type of New Vantage® policy.
    - If the premium amount submitted with the application is more than the amount required for insurance applied for, a refund will be generated for the difference. If the premium amount submitted with the application is less than the amount required for insurance applied for, we will request the additional amount required at the time the policy is delivered.

How to Avoid Delays

- Ensure that all sections of the application are signed as required:
    - Section 11 (Automatic Check, Debit/Credit Card Plan Authorization) **must be** signed by the payer/account holder.
    - Section 12 (Authorization for Consumer Report and Acknowledgment) **must be** signed by the proposed insured, and the owner if other than the proposed insured.
    - Section 13 (Agents Disclosure) **must be** signed by the producer.
    - Conditional Coverage Receipt **must be** signed by the producer.
- Distribute the following sections of the Application as required:
    - Investigative Consumer Report Notice to Applicant **must be** left with the proposed insured
    - Conditional Coverage Receipt **must be** left with the owner if the first month's premium is paid.
- If replacing existing insurance or annuity, ensure that the applicable replacement form(s) has been completed. Leave one copy with the insured and return one with the application.
- Ensure that the Authorization to Release Confidential Medical Information is completed and returned with the application.
- List any special policy issuing instructions in the Agent Notes area in Section 13.

Payment of Premiums

- Cash is not permitted for the payment of premium(s).
- Payments by check or money order must be made payable to Sentinel Security Life.
- If the first premium payment is being made by check or money order it must be dated no later than the date the Application was signed by the owner unless a post date is requested.
- If the first premium payment is being made by ACP make sure the payer is aware that the ACP authorization is effective immediately unless a post date is requested.
- Producer cannot make premium payments (unless the proposed insured is the producer or a dependent of the producer).

Completing the Telephone Interview

- Call Apptical at 800-737-6972 to complete the telephone interview portion of the application.
- Include the case number in the Agent Notes area in Section 13 when the interview is completed.
- If the telephone interview cannot be completed at the time of sale, list the reason and the best time to call in the Agent Notes area of Section 13, and the home office will arrange to have it completed.

Faxing and Shipping Instructions

- Mail to: Sentinel Security Life. Attn: New Business, PO Box 65478, Salt Lake City UT 84165.
- Courier to: Sentinel Security Life. Attn: New Business, 1405 West 2200 South, Salt Lake City, UT 84119.
- Fax to: Sentinel Security Life. Attn: New Business, fax number 888-433-4795.
    - Fax a copy of the application, check and all applicable forms. **Note:** Original money orders and cashier's checks must be mailed. Please indicate that a payment has been mailed in the Agent's Notes section of the faxed application.
    - Once all forms are faxed, do not mail the originals.

APPLICATION FOR INDIVIDUAL LIFE INSURANCE Print - Use Black Ink	SENTINEL SECURITY LIFE INSURANCE COMPANY PO Box 65478 Salt Lake City, Utah 84165 Phone: 1-800-247-1423	*Home Office Use Only*

1. PROPOSED INSURED:

First Name	Middle	Last	State of Birth	Birthdate	Age Last Birthday	Sex M☐ F☐	Marital Status M☐ S☐

2.a CURRENT ADDRESS:			**2.b MAILING/BILLING ADDRESS (if different than 2.a):**		
Street		How Long?	Street or Box No.		
City	State	Zip	City	State	Zip

Day Phone Number ( )	Evening Phone Number ( )	
E-Mail Address	Social Security No. - -	Proposed Effective Date

3. EMPLOYMENT:

Job Title	Employer Name	Employer Address

4. BENEFICIARY:

Primary Beneficiary:	Phone Number ( )	Relationship

Address of Primary Beneficiary	City	State	Zip

Contingent Beneficiary:	Phone Number ( )	Relationship

Address of Contingent Beneficiary	City	State	Zip

5. OWNER:

Name	Relationship	Social Security No.
Address	Phone Number ( )	- -

6. AUTOMATIC PREMIUM LOAN:

Is the Automatic Premium Loan provision (if available) to be made operative? ☐ Yes ☐ No

7. HEALTH INFORMATION:

Has the Proposed Insured used any nicotine products in the past 12 months (excluding occasional cigar/pipe use?)..... Yes ☐ No ☐

Please state the Proposed Insured's height _____ and weight _____

Are you currently taking any medications? If yes, complete the table below. (List additional medication on a separate sheet.)

Medication Name (copy off pharmacy label)		Medication Name (copy off pharmacy label)	
Diagnosis/Condition		Diagnosis/Condition	

Part A - if any question is answered "Yes," the Applicant is not eligible for coverage (Circle any impairments that apply)

	Yes	No
1. Is the Proposed Insured currently: bedridden, confined to a nursing or correctional facility, receiving hospice or home health care, received or been advised to receive an organ or tissue transplant, or been hospitalized within the last 3 months?.....	☐	☐
2. Does the Proposed Insured currently use a wheelchair due to a chronic illness or disease, or require assistance with activities of daily living such as bathing, dressing, eating or toileting?.....	☐	☐
3. Has the Proposed Insured been medically treated or diagnosed by a licensed member of the medical profession, or taken medication for:		
a. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)?.....	☐	☐
b. Alzheimer's, dementia, Lou Gehrig's Disease (ALS), Huntington's Disease, or **prior to age 25**, Cerebral Palsy, Down's Syndrome, spina bifida, cystic fibrosis, mental retardation, or muscular dystrophy?	☐	☐
c. A terminal medical condition that would reasonably be expected to cause death within the next **12 months**?.....	☐	☐
4. Has the Proposed Insured, within the past **12 months,** been advised to have a diagnostic test, surgery, dialysis, home health care or hospitalization which has not yet been **started, completed or for which results are not known?**.....	☐	☐

7. HEALTH INFORMATION - Continued - Circle any impairments that apply:

Part B - if any question is answered "Yes," the Proposed Insured may be eligible for the Sentinel Plan New Vantage® III

	Yes	No
1. Within the past **2 years**, has the Proposed Insured been medically treated or diagnosed by a licensed member of the medical profession, or taken medication for:		
a. Drug or alcohol dependency/habit or treatment for alcoholism or drug addiction or manic depression or schizophrenia?	☐	☐
b. Heart attack, congestive heart failure, cardiomyopathy, stroke, Transient Ischemic Attack (TIA), aneurysm, or had heart or circulatory surgery?	☐	☐
c. Treatment for insulin shock, diabetic coma, neuropathy, had an amputation or any other complication from diabetes?	☐	☐
2. Within the past **3 years**, has the Proposed Insured been medically treated or diagnosed by a licensed member of the medical profession or taken medication for: brain tumor, internal cancer, malignant melanoma, leukemia or sickle cell anemia?	☐	☐

Part C - if any question is answered "Yes," the Proposed Insured may be eligible for the Sentinel Plan New Vantage® II

	Yes	No
1. Within the past **5 years**, has the Proposed Insured been diagnosed or treated by a licensed member of the medical profession or taken medication for:		
a. Coronary Artery Disease, heart attack, heart surgery to include heart bypass, angioplasty, balloon procedure, stent placement or heart valve replacement, pacemaker/defibrillator, stroke, aneurysm, angina, chest pain, or any other heart or circulatory disorder?	☐	☐
b. Chronic disorder which requires the use of oxygen, or Chronic Obstructive Pulmonary Disease (COPD), which includes emphysema, chronic asthma, or chronic bronchitis?	☐	☐
c. Parkinson's Disease, Kidney Disease, kidney failure, cirrhosis or other liver disease or any auto-immune disorder including Rheumatoid Arthritis, Systemic Lupus (SLE) or Sjogren's?	☐	☐
d. Diabetes treated by insulin more than 50 units daily?	☐	☐

If all questions in Part A, B and C are answered "No," the Proposed Insured may be eligible for the Sentinel Plan New Vantage® I

8. POLICY AND PREMIUM INFORMATION:

Plan Applied For: ☐ **New Vantage® I** ☐ Full Pay ☐ Single Premium ☐ 10-Pay ☐ 20-Pay ☐ Paid-Up 65 ☐ Paid-Up 85

☐ **New Vantage® II** ☐ **New Vantage® III**

Include additional benefits indicated below (New Vantage® I only):

☐ W.P.D. ☐ A.D. $_____ ☐ Children's Protection Rider (Units Per Child) $_____

Amount of Insurance $_____ Premium Amount (include riders) $_____ Amount Collected $_____

Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly **(direct monthly not available - Complete Section 11)**

9. CHILDREN (if Children's Protection Rider is applied for):

	First Name Middle Last	Birthdate	Age Last Birthday	Sex	HT.	WT.	Relation
Are all unmarried children under 18 listed here? ☐ Yes ☐ No Do all children listed here live with applicant? ☐ Yes ☐ No (If "no" explain in Section 13 Agent Notes area.)							

10. OTHER INSURANCE:

	Yes	No
a. Does the Proposed Insured currently have any life insurance or annuity in force?	☐	☐
b. Will insurance applied for in this Application replace, reduce coverage or modify premiums paid for any existing life insurance or an annuity in force?	☐	☐

If either question is answered "yes," complete the required Replacement Form(s), and list all life insurance coverage below.

	Yes	No
c. Are any other applications pending with other companies?	☐	☐

INSURED OR ANNUITANT	INSURER NAME	CONTRACT OR POLICY #	OWNER	REPLACEMENT YES NO	AMOUNT	YEAR ISSUED
				☐ ☐		
				☐ ☐		

11. AUTOMATIC CHECK, DEBIT / CREDIT CARD PLAN AUTHORIZATION:

I would like my direct payment to come from my (check one): **Checking** ☐ **Savings** ☐ on the _____ day of the month.
Note: If checking account attach voided blank check.

Routing No. _____ Account No. _____

Financial Institution _____

I would like my **initial** payment to come from my (check one): **Visa** ☐ **Master Card** ☐ **Discover** ☐
(Initial premium only)

Credit Card Account No. _____ Exp. Date (mo/yr) ____/____ Name on Card _____

Address (must match statement) _____ City, State, Zip _____

I hereby request and authorize Sentinel to initiate a charge to my account at the named Financial Institution to pay the premium(s) due, after the first premium has been paid, on any life insurance policy issued in connection with this application. The term "charge" shall include items initiated by electronic means, checks, drafts or any other order including charges to my debit/credit card.
I have the right to stop payment of a charge by giving notice to Sentinel or the Financial Institution in such time as to afford a reasonable opportunity to act prior to charging my account. I agree that Sentinel's rights in respect to each charge shall be the same as if it were a check drawn on me and personally signed by me. If any charge is dishonored for any reason, Sentinel shall not be under any liability even though such dishonor results in the forfeiture of insurance.

_____ _____
Date Signature of Account Holder

12. AUTHORIZATION FOR CONSUMER REPORT AND ACKNOWLEDGMENT:

I have read the questions and answers in all parts of this application, and agree that they are complete and true to the best of my knowledge and belief. I agree that this application shall form a part of any policy issued. I understand the Company may obtain an investigative consumer report on me, and a telephone interview may be necessary to verify or supplement information given to the Company on this application. I understand my right to request to be interviewed, and that I may request a copy of the report if no personal interview is conducted. A photocopy of this form will be as valid as the original; this Authorization and Acknowledgment will be valid for 24 months after it is signed.
I have received and read the Notice to Applicant, and I have read and signed the Authorization to Release Confidential Medical Information.

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

Signed At _____ _____
City State Signature of Proposed Insured (or Parent or Guardian of Minor Child)

_____ _____
Agent Date Signature of Owner if Different

13. AGENTS DISCLOSURE:

I certify that the answers on this application are full, complete and true to the best of my knowledge, and that I know of no factors affecting the insurability of the Proposed Insured except as stated herein. To the best of my knowledge the Proposed Insured does ☐, does not ☐, have existing life insurance or annuities. To the best of my knowledge the insurance applied for will not replace any existing life insurance or annuities unless as otherwise explained.

Licensed Agent _____ Agent's No. _____ Split Agent Name _____

Agent Signature _____ Date _____ Split Agent Number _____

Split Percentage _____

Send policy to: Agent ☐ Insured ☐

AGENT NOTES

HOME OFFICE USE ONLY

Sentinel Security Life Insurance Company
Administrative Office
P.O. Box 65478
Salt Lake City, UT 84165

INVESTIGATIVE CONSUMER REPORT NOTICE TO APPLICANT

Federal law requires that notice of investigation be given to persons applying for insurance. In making this application for insurance to Sentinel Security Life Insurance Company (the Company), it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living (the term "mode of living," does not relate directly or indirectly to the sexual orientation of any Proposed Insured). You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon proper identification, you have the right to inspect and/or receive a copy of the report from the consumer reporting agency. You have the right to make a written request to the Company within a reasonable period of time to receive additional detailed information about the nature and scope of the investigation. Write to: Underwriting Department, Sentinel Security Life Insurance Company, P.O. Box 65478, Salt Lake City, Utah, 84165.

MIB INC. DISCLOSURE NOTICE

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

LEAVE WITH PROPOSED INSURED

LIFE INSURANCE CONDITIONAL COVERAGE RECEIPT

(Void if altered or modified, or if check or draft given in payment is not honored. **Note: Detach if full first life premium is not paid.**)
Received from _____ $ _____ subject to the terms and conditions below, for the full first premium with the application bearing the date of this receipt.
Coverage under any policy issued from an application bearing the date of this receipt will take effect on the later of the following dates: (1) the date of the application; or (2) the date of the last of any medical exams or tests, if required. Coverage will take effect only if each and every one of these conditions have been met: (1) all persons proposed for insurance are in good health; (2) the first full premium is paid on the date of the application; and (3) upon receipt of the application, and of any further information required, all persons are insurable as of that date: (a) as determined by Sentinel Security Life Insurance Company (Company) at its home office according to its rules and practices; and (b) at the standard rates for insurance exactly as applied for. The maximum amount of life insurance (excluding accidental death benefits) on the Proposed Insured, (combined with any issued or pending with the Company) which will take effect under this receipt shall not exceed $50,000.
Coverage under any policy not issued exactly as applied for or in excess of the maximum amounts stated above will only take effect: (1) when this policy is delivered to and accepted by the applicant; and (2) upon payment of the first premium for such coverage. This must occur during the lifetime and good health of all persons proposed for insurance (including accidental death benefits).
If a proposed insured dies by suicide while sane or self destruction while insane, we will pay only a refund of all premiums paid.
Except as stated above, no insurance will take effect and the liability of the Company is limited to a refund of any amount paid. Any application not accepted or declined will be deemed declined on the 60th day after its date.

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

LEAVE WITH OWNER IF FIRST MONTH'S PREMIUM IS PAID

Sentinel Security Life Insurance Company
Administrative Office
P.O. Box 65478
Salt Lake City, UT 84165
1-800-247-1423

Authorization to Release Confidential Medical Information

Records and information obtained will be disclosed to Sentinel Security Life Insurance Company for the purpose of 1) evaluating my application for insurance; 2) obtain reinsurance; 3) determine or fulfill responsibility for coverage and provision of benefits; 4) and administer coverage.

I, the undersigned, hereby authorize any and all medical practitioners, physicians, pharmacists, hospitals, clinics, nurses, records custodians, MIB, Inc., or anyone else to release any and all records and information to be exchanged between Sentinel Security Life Insurance Company and its agents, reinsurer(s), contractors, employees, representatives, and affiliates, and its assigns as necessary to fulfill the purpose of this disclosure.

I hereby authorize you to release any and all records and information within your possession, custody or control regarding me pursuant to this Authorization. Any and all records and information regarding diagnosis, testing, treatment and prognosis of my physical or mental condition are to be released. Such records and information to be released may include, but not be limited to, the following: alcohol abuse treatment, drug abuse treatment, psychiatric treatment, pharmacy prescriptions, HIV testing and treatment, STD testing and treatment, genetic testing, Sickle Cell testing and treatment, lab data and EKG's.

I authorize Sentinel Security Life Insurance Company, or its reinsurers, to make a brief report of my protected personal health information to MIB, Inc.

I understand that when information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the insurance company and may no longer be protected by the same rule that applied in the first instance. This Authorization will remain in effect a maximum of two (2) years from my date of signature below. I understand I may revoke this Authorization in writing, at any time, by sending a written request for revocation to Sentinel Security Life Insurance Company at the address listed above, unless action has already been taken in reliance upon it, or during a contestability period under applicable law. A photocopy of this Authorization will be treated in the same manner as the original.

I understand that if I refuse to sign this Authorization to release complete medical records, Sentinel Security Life Insurance Company may not be able to process my application. I understand that I or my authorized representative may request a copy of this Authorization.

_____

Name of Proposed Insured (please print)

_____

Signature of Proposed Insured

_____

Date

RETURN TO COMPANY

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 interests. 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 back 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 documents 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.)

RETURN TO HOME OFFICE

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 interests. 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 back 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 documents 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.)

LEAVE WITH APPLICANT

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 and financial stability of the new company compare with your existing company?

NON-RESIDENT VERIFICATION FORM

For questions, please contact Sentinel Security Life Insurance New Business Department
Phone: (800) 247-1423 opt 3, 3, 1 • Fax: (801) 665-1813 or (888) 433-4795 • Email: newbusiness@sslco.com
Mail to: PO Box 65478, Salt Lake City, UT 84165 • Express Mail to: 1405 West 2200 South, Salt Lake City, Utah 84119

This form can be used to assist you in providing the required documentation if an application is signed in a state other than the applicant/owner "Resident State."

Definitions

Resident State- is defined for this purpose as the state where a client or owner has his or her residence and receives mail on a regular basis. A residence can be a primary residence or vacation home. Please note, that a "Time Share" will be considered a temporary residence and therefore does not qualify for a primary residence under this form.

For business entity, "Residence State" is defined as the state where the business entity has its primary place of business or place of incorporation. For trusts, "Resident State" is defined as the state where the trust is located or where the trustee has an office or primary residence.

Application State- is where the applicant/ owner signed the application and where the policy is solicited, paramedic exam is scheduled (if applicable), and policy/contract is delivered. The "Application State" must be a state where the agent is licensed and the product is approved.

When a product is not available for sale in the owner's resident state, a resident is only allowed to purchase the product in another state if they provide a valid reason to be in the non-resident state, other than solely to purchase the product*.

I _____(Owner/ Joint Owner) am a resident of the state of _____

My valid reasons for being in the Application Signed State of _____is (other than to purchase an annuity or insurance)

_____

_____

_____

Acknowledgments

All communications, sales material and negotiations of the application occurred in the Application State.
The application was signed by the owner and the agent in the Application State.
The owner will take delivery of the policy/contract issued in the Application State.

I understand that the solicitation for this policy and contract occurred in the Application State and that the laws of the Application State will govern all legal rights and obligations under the policy/contract applied for.

Owner Signature: _____ Date: _____

Agent Signature: _____ Date: _____

*State Restrictions- Alabama, Massachusetts, Minnesota, Oregon, Utah and Washington - Purchase of products outside these resident states is not allowed if they are not available for sale in the resident state.

Sentinel Security Life

COMMUNITY PROPERTY STATES SPOUSAL EXISTENCE/BENEFICIARY DESIGNATION CONSENT FORM

CONTRACT INFORMATION:

Name of Contract Owner: _____ Contract Number (if known): _____

Spousal Existence:

I currently am a resident of one of the community property states: Arizona, California, Idaho, Louisiana, New Mexico, Nevada, Texas, Washington or Wisconsin.

I currently: (Check one)

- ☐ Do have a spouse -spousal consent and spousal signature required below **if** spouse is **not** sole primary beneficiary.
- ☐ Do not have a spouse.

Signature of Contract Owner

This form dated at (City/State)_____on the_____day of_____,20_____

Signature of Owner _____

Owner's Email Address _____ Owner's Telephone Number _____

Spousal

I have reviewed the beneficiary designation dated _____ for the contract number above, and as the spouse of the contract owner, I consent to the beneficiary designation and all contributions of money or property to be used for the purchase of such accounts to be issued in my spouse's name, whether heretofore, now or hereafter, and I relinquish all my statutory or other rights thereto.

Signature of Spouse

This form dated at (City/State)_____on the_____day of_____,20_____

Signature of Owner's Spouse_____

Spouse's Email Address_____ Spouse's Telephone Number_____

SEPARATE FORM FOR EACH CONTRACT IS REQUIRED

For Home Office Use Only

Recorded By: _____ Date: _____

PO Box 65478, Salt Lake City, UT 84165 • Toll Free 800-247-1423 • Fax 888-433-4795

NOTES

Sentinel Security Life

Sentinel Security Life Insurance Company

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

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

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



SENTINEL SECURITY LIFE INSURANCE COMPANY
PO BOX 65478 SALT LAKE CITY, UTAH 84165