

Louisiana

*2011 SELECT Medicare
Supplement Insurance Plan*

*Sentinel
Security Life*



2011 Medicare Select Insurance Plans On Your Team

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

What's more, you have:

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

Your choice of physicians and specialists for your personalized care.

Virtually no claims paperwork to file.

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

About Us

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

Medicare Supplement insurance is underwritten by:

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

Choose the Medicare Supplement Plan that's Right for You

Choose the Medicare Select Plan that's Right for You

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

* Your Medicare Select plan pays the Medicare Part A inpatient deductible when you use a network hospital (or if you use a non-network hospital for emergency care). Otherwise, you pay the inpatient deductible.

Medicare Part A Hospital Coverage

Deductible -

When you use a network hospital, the \$1,132 inpatient hospital deductible for each benefit period is waived. If you choose a non-network hospital, you are responsible for the Medicare Part A deductible. Of course, if you need emergency care, you may go to any hospital and the deductible will be waived.

First 60-days -

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

Co-Insurance –

Sentinel Security Select Plans C, D, F & N pay \$283 a day when you are hospitalized from the 61st day through the 90th day. When you are hospitalized from the 91st day through the 150th day, Sentinel Security Select Plans pay \$566 a day for each Lifetime Reserve day used.

Extended Hospital Coverage –

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

Benefit for Blood –

Medicare has one calendar year deductible for blood that is the cost of the first three pints. Sentinel Security Select Plans C, D, F & N pay the deductible.

Skilled Nursing Facility Care –

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

Hospice Care –

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

Medicare Part B Physician Services and Supplies

Deductible -

Sentinel Security Select Plans C & F pay the \$162 calendar-year deductible.

Co-Insurance –

After the Part B Deductible, Sentinel Security Select Plans C, D & F generally pay 20% of Medicare approved expenses for physician's services, and supplies, physical and speech therapy and ambulance service.

After the Part B deductible, Plan N pays 20% of the eligible expenses for physician's services, supplies, physical and speech therapy and ambulance services except up to a \$20 co-payment for office visits and up to a \$50 co-payment for emergency room visits.

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

Excess Benefits –

Your bill for Part B services and supplies may exceed the Medicare eligible expense. When that occurs, Sentinel Security Select Plan F pays 100% up to the charge limitation established by Medicare. This benefit would apply when you receive services outside the network, or services from providers that are allowed to balance bill.

Benefit for Blood –

Medicare has one calendar year deductible for blood that is the cost of the first three pints. Sentinel Security Select Plans C, D, F & N pay the deductible.

Additional Benefits**

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

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

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

Your Medicare Select insurance policy will not pay for the following exceptions and limitations:

- Any expense incurred before your Policy Date
- Hospital or skilled nursing facility confinement incurred during a Medicare Part A benefit period that begins while this policy is not in force.
- Expense paid for by Medicare; services for non-Medicare eligible expenses.
- Services for which no charge is made when there is no insurance.
- Loss or expense that is payable under any other Medicare Supplement insurance policy or certificate.
- The Medicare Part A inpatient hospital deductible amount when you are confined in a non-network hospital, except in an emergency.

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

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

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

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

A “Network Provider Hospital” means a hospital which has agreed to participate in the Hospital Network.

Benefits are paid to you, your hospital or doctor.

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

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

You cannot be singled out for a rate increase no matter how many times you receive benefits. Your premium changes only (a) each year on the renewal date coinciding with or following the anniversary of your Policy Date until you reach age 99; and (b) when the same premium change is made on all in force Sentinel Security Select policies of the same form issued to persons of your classification in the same geographic area of your state.

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

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

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

SENTINEL SECURITY LIFE INSURANCE COMPANY

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

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

Outline of Medicare Supplement Coverage – Cover Page

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

Basic Benefits:

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

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

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

Blood: First three pints of blood each year.

Hospice: Part A coinsurance.

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

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

Plans C, D, F and N are also offered as

Medicare Supplement Select Plans. If you

choose a Medicare Select plan, when medical

care is provided in a Participating Hospital, the

Initial Part A Deductible is waived. If medical

care is not provided in a Participating Hospital,

you are responsible for payment of the Initial

Part A Deductible. Medicare Supplement

Select Plans are not available in all states.

* Plan F also has an option called a high deductible Plan F.

This high deductible plan pays the same benefits as Plan

F after one has paid a calendar year \$2,000 deductible.

Benefits from high deductible Plan F will not begin until

out-of-pocket expenses exceed \$2,000. Out-of-pocket

expenses for this deductible are expenses that would

ordinarily be paid by the policy. These expenses include

Medicare deductibles for Part A and Part B, but do not

include the plan's separate foreign travel emergency

deductible.

SENTINEL SECURITY LIFE INSURANCE COMPANY

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

PREMIUM INFORMATION

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

There will be a one-time enrollment fee of \$25.00 added to the first premium.

DISCLOSURES

Use this Outline to compare benefits and premiums among policies.

READ YOUR POLICY VERY CAREFULLY

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

30-DAY RIGHT TO RETURN POLICY

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

POLICY REPLACEMENT

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

NOTICE

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

COMPLETE ANSWERS ARE VERY IMPORTANT

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

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

RENEWABILITY

This Policy is guaranteed renewable for life.

SENTINEL SECURITY LIFE INSURANCE COMPANY
MONTHLY RATES*

SELECT PLANS - NON-TOBACCO
ZIP CODES: 703, 705-706, 710-714

Female					Attained Age	Male			
Select Plan C SSLC10SL- LA	Select Plan D SSLD10SL- LA	Select Plan F SSLF10SL- LA	Select Plan N SSLN10SL- LA			Select Plan C SSLC10SL- LA	Select Plan D SSLD10SL- LA	Select Plan F SSLF10SL- LA	Select Plan N SSLN10SL- LA
\$200.99	\$169.35	\$205.84	\$137.54		Under 65	\$231.14	\$194.75	\$236.71	\$158.17
85.53	72.06	87.59	58.53		65	98.36	82.87	100.73	67.30
88.34	74.41	90.47	60.42		66	101.59	85.57	104.04	69.48
92.13	77.57	94.35	62.98		67	105.95	89.21	108.50	72.42
95.17	80.13	97.46	65.06		68	109.44	92.15	112.08	74.82
98.31	82.80	100.68	67.24		69	113.06	95.22	115.79	77.33
101.37	85.41	103.82	69.39		70	116.58	98.22	119.39	79.79
104.32	87.93	106.83	71.46		71	119.97	101.12	122.86	82.18
107.16	90.37	109.74	73.47		72	123.24	103.92	126.21	84.49
109.77	92.61	112.41	75.32		73	126.24	106.50	129.28	86.61
112.20	94.71	114.89	77.06		74	129.03	108.92	132.13	88.62
115.53	97.59	118.30	79.45		75	132.86	112.22	136.05	91.37
120.01	101.44	122.89	82.63		76	138.01	116.66	141.33	95.03
122.11	103.28	125.04	84.18		77	140.43	118.78	143.80	96.81
125.30	106.05	128.31	86.48		78	144.10	121.95	147.55	99.45
127.24	107.75	130.29	87.92		79	146.32	123.92	149.83	101.10
129.19	109.47	132.28	89.36		80	148.57	125.89	152.12	102.77
131.09	111.15	134.22	90.78		81	150.75	127.82	154.35	104.40
134.21	113.87	137.41	93.06		82	154.34	130.95	158.03	107.02
135.95	115.42	139.20	94.38		83	156.34	132.73	160.08	108.54
137.67	116.96	140.95	95.70		84	158.32	134.50	162.09	110.05
140.65	119.58	144.01	97.90		85	161.75	137.51	165.61	112.58
142.33	121.08	145.72	99.19		86	163.68	139.25	167.58	114.07
144.07	122.65	147.50	100.54		87	165.68	141.05	169.63	115.62
145.76	124.18	149.22	101.85		88	167.62	142.81	171.60	117.13
147.46	125.75	150.96	103.20		89	169.58	144.62	173.61	118.68
150.65	128.60	154.22	105.60		90	173.24	147.89	177.36	121.44
152.47	130.28	156.08	107.04		91	175.34	149.82	179.50	123.10
154.36	132.02	158.02	108.55		92	177.52	151.83	181.72	124.83
156.30	133.81	160.01	110.08		93	179.75	153.88	184.01	126.60
158.35	135.69	162.09	111.71		94	182.10	156.05	186.41	128.46
161.90	138.87	165.73	114.39		95	186.19	159.70	190.58	131.55
163.96	140.77	167.83	116.04		96	188.55	161.89	193.00	133.44
165.93	142.60	169.84	117.62		97	190.82	163.99	195.32	135.26
167.93	144.46	171.89	119.23		98	193.12	166.13	197.67	137.11
169.99	146.37	173.99	120.89		99	195.49	168.32	200.09	139.02

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

SENTINEL SECURITY LIFE INSURANCE COMPANY
MONTHLY RATES*

SELECT PLANS - TOBACCO
ZIP CODES: 703, 705-706, 710-714

Female				Attained Age	Male			
Select Plan C SSLC10SL- LA	Select Plan D SSLD10SL- LA	Select Plan F SSLF10SL- LA	Select Plan N SSLN10SL- LA		Select Plan C SSLC10SL- LA	Select Plan D SSLD10SL- LA	Select Plan F SSLF10SL- LA	Select Plan N SSLN10SL- LA
\$231.14	\$194.75	\$236.71	\$158.17	Under 65	\$265.81	\$223.96	\$272.22	\$181.89
98.36	82.87	100.73	67.30	65	113.11	95.30	115.84	77.40
101.59	85.57	104.04	69.48	66	116.83	98.40	119.64	79.90
105.95	89.21	108.50	72.42	67	121.84	102.59	124.78	83.29
109.44	92.15	112.08	74.82	68	125.86	105.97	128.90	86.04
113.06	95.23	115.79	77.33	69	130.02	109.51	133.16	88.93
116.58	98.22	119.39	79.79	70	134.06	112.96	137.30	91.76
119.97	101.12	122.86	82.18	71	137.97	116.29	141.29	94.50
123.24	103.92	126.21	84.49	72	141.72	119.51	145.14	97.16
126.24	106.50	129.28	86.61	73	145.17	122.48	148.67	99.61
129.03	108.92	132.13	88.62	74	148.38	125.25	151.95	101.92
132.86	112.22	136.05	91.37	75	152.78	129.06	156.46	105.07
138.01	116.66	141.33	95.03	76	158.72	134.16	162.53	109.28
140.43	118.78	143.80	96.81	77	161.50	136.60	165.37	111.33
144.10	121.95	147.55	99.45	78	165.71	140.25	169.69	114.37
146.32	123.92	149.83	101.10	79	168.27	142.50	172.30	116.27
148.57	125.89	152.12	102.77	80	170.85	144.77	174.94	118.18
150.75	127.82	154.35	104.40	81	173.36	146.99	177.51	120.06
154.34	130.95	158.03	107.02	82	177.49	150.59	181.73	123.07
156.34	132.73	160.08	108.54	83	179.79	152.64	184.09	124.82
158.32	134.50	162.09	110.05	84	182.06	154.68	186.41	126.56
161.75	137.51	165.61	112.58	85	186.02	158.14	190.45	129.47
163.68	139.25	167.58	114.07	86	188.23	160.13	192.72	131.18
165.68	141.05	169.63	115.62	87	190.54	162.21	195.07	132.96
167.62	142.81	171.60	117.13	88	192.76	164.23	197.35	134.70
169.58	144.62	173.61	118.68	89	195.02	166.31	199.65	136.48
173.24	147.89	177.36	121.44	90	199.23	170.07	203.96	139.66
175.34	149.82	179.50	123.10	91	201.64	172.29	206.42	141.57
177.52	151.83	181.72	124.83	92	204.14	174.60	208.98	143.55
179.75	153.88	184.01	126.60	93	206.71	176.97	211.61	145.59
182.10	156.05	186.41	128.46	94	209.42	179.46	214.37	147.73
186.19	159.70	190.58	131.55	95	214.12	183.66	219.17	151.29
188.55	161.89	193.01	133.44	96	216.84	186.17	221.96	153.46
190.82	163.99	195.32	135.26	97	219.44	188.59	224.62	155.55
193.12	166.12	197.67	137.11	98	222.09	191.04	227.32	157.68
195.49	168.32	200.09	139.02	99	224.81	193.57	230.10	159.87

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

SENTINEL SECURITY LIFE INSURANCE COMPANY
MONTHLY RATES*

SELECT PLANS - NON-TOBACCO
ZIP CODES: 707-708

Female					Attained Age	Male			
Select Plan C SSLC10SL- LA	Select Plan D SSLD10SL- LA	Select Plan F SSLF10SL- LA	Select Plan N SSLN10SL- LA			Select Plan C SSLC10SL- LA	Select Plan D SSLD10SL- LA	Select Plan F SSLF10SL- LA	Select Plan N SSLN10SL- LA
\$215.06	\$181.20	\$220.25	\$147.16		Under 65	\$247.32	\$208.38	\$253.28	\$169.24
91.52	77.11	93.72	62.62		65	105.24	88.67	107.78	72.02
94.52	79.61	96.80	64.65		66	108.70	91.56	111.32	74.34
98.58	83.00	100.96	67.39		67	113.36	95.45	116.10	77.49
101.83	85.74	104.29	69.61		68	117.10	98.60	119.93	80.05
105.20	88.60	107.73	71.95		69	120.97	101.89	123.89	82.74
108.47	91.39	111.08	74.24		70	124.74	105.10	127.74	85.38
111.62	94.09	114.31	76.46		71	128.37	108.20	131.46	87.93
114.66	96.69	117.43	78.61		72	131.86	111.20	135.04	90.40
117.46	99.09	120.28	80.59		73	135.07	113.96	138.33	92.68
120.05	101.34	122.94	82.46		74	138.06	116.54	141.38	94.83
123.61	104.42	126.58	85.01		75	142.16	120.08	145.57	97.76
128.41	108.54	131.50	88.42		76	147.68	124.83	151.22	101.68
130.66	110.51	133.80	90.08		77	150.26	127.09	153.87	103.59
134.07	113.47	137.29	92.53		78	154.18	130.49	157.88	106.41
136.14	115.29	139.41	94.07		79	156.57	132.59	160.32	108.18
138.23	117.13	141.54	95.62		80	158.97	134.70	162.77	109.96
140.26	118.93	143.62	97.14		81	161.30	136.77	165.16	111.71
143.60	121.84	147.03	99.57		82	165.14	140.11	169.09	114.51
145.47	123.50	148.94	100.99		83	167.29	142.02	171.28	116.14
147.30	125.14	150.82	102.39		84	169.40	143.92	173.44	117.75
150.50	127.95	154.09	104.75		85	173.08	147.14	177.20	120.46
152.29	129.56	155.92	106.13		86	175.14	148.99	179.31	122.05
154.16	131.24	157.83	107.57		87	177.28	150.92	181.50	123.71
155.96	132.87	159.67	108.98		88	179.35	152.80	183.62	125.32
157.78	134.56	161.53	110.42		89	181.45	154.74	185.76	126.99
161.19	137.60	165.02	112.99		90	185.37	158.24	189.77	129.94
163.14	139.40	167.01	114.54		91	187.61	160.31	192.06	131.72
165.17	141.26	169.08	116.14		92	189.94	162.45	194.44	133.57
167.25	143.18	171.21	117.79		93	192.33	164.66	196.89	135.46
169.43	145.19	173.44	119.53		94	194.85	166.97	199.46	137.45
173.23	148.59	177.33	122.40		95	199.22	170.88	203.93	140.76
175.44	150.63	179.58	124.16		96	201.75	173.22	206.51	142.78
177.54	152.58	181.73	125.85		97	204.18	175.47	208.99	144.73
179.69	154.57	183.92	127.57		98	206.64	177.75	211.51	146.71
181.89	156.61	186.17	129.35		99	209.17	180.11	214.10	148.75

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

SENTINEL SECURITY LIFE INSURANCE COMPANY
MONTHLY RATES*

SELECT PLANS - TOBACCO
ZIP CODES: 707-708

Female				Attained Age	Male			
Select Plan C SSL10SL- LA	Select Plan D SSLD10SL- LA	Select Plan F SSLF10SL- LA	Select Plan N SSLN10SL- LA		Select Plan C SSLC10SL- LA	Select Plan D SSLD10SL- LA	Select Plan F SSLF10SL- LA	Select Plan N SSLN10SL- LA
\$247.32	\$208.38	\$253.29	\$169.24	Under 65	\$284.42	\$239.64	\$291.28	\$194.62
105.24	88.67	107.78	72.02	65	121.03	101.97	123.95	82.82
108.70	91.56	111.32	74.35	66	125.00	105.29	128.02	85.50
113.36	95.45	116.10	77.49	67	130.37	109.77	133.51	89.12
117.10	98.60	119.93	80.05	68	134.67	113.39	137.92	92.06
120.97	101.89	123.89	82.75	69	139.12	117.17	142.48	95.16
124.74	105.10	127.74	85.38	70	143.45	120.86	146.91	98.19
128.37	108.20	131.46	87.93	71	147.62	124.43	151.18	101.12
131.86	111.20	135.04	90.40	72	151.64	127.88	155.30	103.96
135.07	113.96	138.33	92.68	73	155.34	131.05	159.07	106.58
138.06	116.54	141.38	94.83	74	158.77	134.02	162.59	109.05
142.16	120.08	145.57	97.76	75	163.48	138.09	167.41	112.43
147.68	124.83	151.22	101.68	76	169.83	143.55	173.91	116.93
150.26	127.09	153.87	103.59	77	172.80	146.16	176.95	119.12
154.18	130.49	157.88	106.41	78	177.31	150.06	181.56	122.37
156.57	132.59	160.32	108.18	79	180.05	152.48	184.37	124.41
158.97	134.70	162.77	109.96	80	182.81	154.91	187.19	126.46
161.30	136.77	165.16	111.71	81	185.49	157.28	189.93	128.46
165.14	140.11	169.09	114.51	82	189.91	161.13	194.45	131.68
167.29	142.02	171.28	116.14	83	192.38	163.33	196.97	133.56
169.40	143.92	173.44	117.75	84	194.81	165.50	199.45	135.42
173.08	147.14	177.20	120.46	85	199.04	169.21	203.78	138.53
175.14	148.99	179.31	122.05	86	201.41	171.34	206.20	140.36
177.28	150.92	181.50	123.71	87	203.87	173.56	208.72	142.27
179.35	152.80	183.62	125.32	88	206.26	175.73	211.16	144.12
181.45	154.74	185.76	126.99	89	208.67	177.95	213.63	146.04
185.37	158.24	189.77	129.94	90	213.18	181.98	218.24	149.43
187.61	160.31	192.06	131.72	91	215.75	184.35	220.87	151.48
189.94	162.45	194.44	133.57	92	218.43	186.82	223.61	153.60
192.33	164.66	196.89	135.46	93	221.18	189.36	226.42	155.78
194.85	166.97	199.46	137.45	94	224.08	192.02	229.37	158.07
199.22	170.88	203.93	140.76	95	229.10	196.51	234.51	161.88
201.75	173.22	206.51	142.78	96	232.02	199.20	237.49	164.20
204.18	175.47	208.99	144.73	97	234.80	201.79	240.34	166.44
206.64	177.75	211.51	146.71	98	237.64	204.42	243.23	168.72
209.17	180.11	214.10	148.75	99	240.55	207.12	246.21	171.06

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

SENTINEL SECURITY LIFE INSURANCE COMPANY
MONTHLY RATES*

SELECT PLANS - NON-TOBACCO
ZIP CODES: 700-701, 704

Female				Attained Age	Male			
Select Plan C SSL10SL- LA	Select Plan D SSLD10SL- LA	Select Plan F SSLF10SL- LA	Select Plan N SSLN10SL- LA		Select Plan C SSLC10SL- LA	Select Plan D SSLD10SL- LA	Select Plan F SSLF10SL- LA	Select Plan N SSLN10SL- LA
\$241.19	\$203.22	\$247.01	\$165.04	Under 65	\$277.37	\$233.70	\$284.06	\$189.80
102.63	86.47	105.11	70.23	65	118.03	99.45	120.87	80.77
106.00	89.29	108.56	72.50	66	121.90	102.68	124.85	83.38
110.55	93.09	113.22	75.57	67	127.14	107.05	130.20	86.91
114.20	96.16	116.96	78.07	68	131.33	110.58	134.50	89.78
117.98	99.36	120.82	80.69	69	135.67	114.27	138.94	92.80
121.64	102.49	124.58	83.26	70	139.89	117.87	143.26	95.75
125.19	105.52	128.20	85.75	71	143.96	121.35	147.43	98.61
128.59	108.44	131.69	88.16	72	147.88	124.71	151.45	101.38
131.73	111.13	134.90	90.38	73	151.49	127.80	155.13	103.94
134.64	113.65	137.87	92.48	74	154.83	130.70	158.56	106.35
138.63	117.10	141.96	95.34	75	159.43	134.67	163.26	109.64
144.02	121.73	147.47	99.16	76	165.62	139.99	169.59	114.03
146.54	123.94	150.05	101.02	77	168.52	142.53	172.56	116.17
150.36	127.25	153.97	103.77	78	172.92	146.34	177.06	119.34
152.69	129.30	156.34	105.50	79	175.59	148.70	179.80	121.32
155.03	131.36	158.74	107.24	80	178.28	151.07	182.55	123.32
157.30	133.38	161.06	108.94	81	180.90	153.38	185.22	125.28
161.05	136.64	164.90	111.67	82	185.20	157.14	189.63	128.42
163.14	138.50	167.03	113.26	83	187.61	159.28	192.09	130.25
165.20	140.35	169.14	114.84	84	189.98	161.40	194.51	132.06
168.79	143.49	172.81	117.48	85	194.10	165.02	198.73	135.10
170.80	145.30	174.87	119.03	86	196.42	167.10	201.09	136.88
172.89	147.18	177.00	120.64	87	198.82	169.26	203.55	138.74
174.91	149.02	179.07	122.22	88	201.14	171.37	205.93	140.55
176.95	150.91	181.16	123.84	89	203.50	173.54	208.33	142.42
180.78	154.32	185.07	126.72	90	207.89	177.47	212.83	145.73
182.96	156.33	187.30	128.45	91	210.41	179.78	215.40	147.72
185.23	158.43	189.62	130.26	92	213.02	182.19	218.07	149.79
187.57	160.57	192.01	132.10	93	215.70	184.66	220.81	151.92
190.02	162.83	194.51	134.05	94	218.52	187.26	223.69	154.15
194.28	166.65	198.87	137.27	95	223.42	191.64	228.70	157.86
196.75	168.93	201.40	139.24	96	226.27	194.27	231.60	160.13
199.12	171.12	203.81	141.14	97	228.98	196.79	234.38	162.31
201.52	173.35	206.26	143.07	98	231.75	199.35	237.21	164.53
203.99	175.64	208.79	145.07	99	234.59	201.99	240.11	166.83

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

SENTINEL SECURITY LIFE INSURANCE COMPANY
MONTHLY RATES*

SELECT PLANS - TOBACCO
ZIP CODES: 700-701, 704

Female				Attained Age	Male			
Select Plan C SSL10SL- LA	Select Plan D SSLD10SL- LA	Select Plan F SSLF10SL- LA	Select Plan N SSLN10SL- LA		Select Plan C SSLC10SL- LA	Select Plan D SSLD10SL- LA	Select Plan F SSLF10SL- LA	Select Plan N SSLN10SL- LA
\$277.37	\$233.70	\$284.06	\$189.80	Under 65	\$318.97	\$268.75	\$326.66	\$218.27
118.03	99.45	120.88	80.77	65	135.73	114.36	139.01	92.88
121.90	102.68	124.85	83.38	66	140.19	118.08	143.57	95.88
127.14	107.05	130.20	86.91	67	146.21	123.11	149.74	99.95
131.33	110.58	134.50	89.78	68	151.03	127.17	154.68	103.25
135.67	114.27	138.94	92.80	69	156.02	131.41	159.79	106.72
139.89	117.87	143.26	95.75	70	160.88	135.55	164.75	110.11
143.96	121.35	147.43	98.61	71	165.56	139.55	169.55	113.40
147.88	124.71	151.45	101.38	72	170.07	143.41	174.16	116.59
151.49	127.80	155.13	103.94	73	174.21	146.97	178.40	119.53
154.83	130.70	158.56	106.35	74	178.06	150.30	182.34	122.30
159.43	134.67	163.26	109.64	75	183.34	154.87	187.75	126.08
165.62	139.99	169.59	114.03	76	190.46	160.99	195.03	131.14
168.52	142.53	172.56	116.17	77	193.79	163.91	198.44	133.60
172.92	146.34	177.06	119.34	78	198.85	168.30	203.62	137.24
175.59	148.70	179.80	121.32	79	201.93	171.00	206.76	139.52
178.28	151.07	182.55	123.32	80	205.02	173.73	209.93	141.82
180.90	153.38	185.22	125.28	81	208.03	176.39	213.01	144.07
185.20	157.14	189.63	128.42	82	212.98	180.71	218.08	147.68
187.61	159.28	192.09	130.25	83	215.75	183.17	220.90	149.78
189.98	161.40	194.51	132.06	84	218.48	185.61	223.69	151.87
194.10	165.02	198.73	135.10	85	223.22	189.77	228.54	155.36
196.42	167.10	201.10	136.88	86	225.88	192.16	231.26	157.41
198.82	169.26	203.55	138.74	87	228.64	194.65	234.08	159.55
201.14	171.37	205.93	140.55	88	231.32	197.08	236.81	161.63
203.50	173.54	208.33	142.42	89	234.02	199.57	239.58	163.78
207.89	177.47	212.83	145.73	90	239.08	204.09	244.75	167.59
210.41	179.78	215.40	147.72	91	241.97	206.75	247.71	169.88
213.02	182.19	218.07	149.79	92	244.97	209.52	250.78	172.26
215.70	184.66	220.81	151.92	93	248.06	212.36	253.93	174.70
218.52	187.26	223.69	154.15	94	251.30	215.35	257.24	177.28
223.42	191.64	228.70	157.86	95	256.94	220.39	263.01	181.54
226.27	194.27	231.61	160.13	96	260.21	223.41	266.35	184.15
228.98	196.79	234.38	162.31	97	263.33	226.30	269.54	186.66
231.75	199.35	237.21	164.53	98	266.51	229.25	272.79	189.22
234.59	201.99	240.11	166.83	99	269.77	232.28	276.12	191.85

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

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

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

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

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

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

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

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

PARTS A & B

HOME HEALTH CARE MEDICARE-APPROVED SERVICES			
<ul style="list-style-type: none"> Medically necessary skilled care services and medical supplies Durable medical equipment - First \$162 of Medicare-approved amounts* - Remainder of Medicare-approved amounts 	100%	\$0	\$0
	\$0 80%	\$0 20%	\$162 (Part B Deductible) \$0

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

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

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

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

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

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

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

PARTS A & B

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

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

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

SERVICES	MEDICARE PAYS	PLAN PAYS	YOU PAY
HOSPITALIZATION* Semiprivate room and board, general nursing and miscellaneous services and supplies First 60 days 61st thru 90th day 91st day and after: <ul style="list-style-type: none"> • While using 60 lifetime reserve days • Once lifetime reserve days are used: <ul style="list-style-type: none"> - Additional 365 days - Beyond the additional 365 days 	All but \$1,132 All but \$283 a day All but \$566 a day \$0 \$0	\$1,132 (Part A Deductible) \$283 a day \$566 a day 100% of Medicare Eligible Expenses \$0	\$0 \$0 \$0 \$0** All Costs
SKILLED NURSING FACILITY CARE* You must meet Medicare's requirements, including having been in a hospital for at least 3 days and entered a Medicare approved facility within 30 days after leaving the hospital. First 20 days 21st thru 100th day 101st day and after	All approved amounts All but \$141.50 a day \$0	\$0 Up to \$141.50 a day \$0	\$0 \$0 All Costs
BLOOD First 3 pints Additional amounts	\$0 100%	3 pints \$0	\$0 \$0
HOSPICE CARE You must meet Medicare's requirements, including a doctor's certification of terminal illness.	All but very limited Co-Insurance for outpatient drugs and inpatient respite care	Medicare copayment/ coinsurance	\$0

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

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

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

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

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

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

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

PARTS A & B

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

PLAN D

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

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

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

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

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

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

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

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

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

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

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

SERVICES		MEDICARE PAYS	PLAN PAYS	YOU PAY
MEDICAL EXPENSES – IN OR OUT OF THE HOSPITAL AND OUTPATIENT HOSPITAL TREATMENT, such as Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment.				
First \$162 of Medicare approved amounts* (the Part B Deductible)		\$0	\$0	\$162 (Part B Deductible)
Remainder of Medicare-approved amounts		Generally 80%	Balance, other than up to \$20 per office visit and up to \$50 per emergency room to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.	Up to \$20 per office visit and up to \$50 per emergency room visit. The copayment of up to \$50 is waived if the insured is admitted to any hospital and the emergency visit is covered as a Medicare Part A expense.
Part B Excess Charges (Above Medicare-approved amounts)		\$0	\$0	All Costs
BLOOD				
First 3 pints		\$0	All costs	\$0
Next \$162 of Medicare approved amounts*		\$0	\$0	\$162 (Part B Deductible)
Remainder of Medicare-approved amounts		80%	20%	\$0
CLINICAL LABORATORY SERVICES – TESTS FOR DIAGNOSTIC SERVICES				
		100%	\$0	\$0

PARTS A & B

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

OTHER BENEFITS – NOT COVERED BY MEDICARE

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

GRIEVANCE PROCEDURE

(MEDICARE SELECT POLICIES ONLY)

GRIEVANCE PROCEDURE

We have a customer service program which can provide information to you, handle your complaints, and help satisfy your concerns. This grievance procedure is intended to provide an opportunity for you and us to achieve mutual agreement for the settlement of disputes that have not been settled through our customer service program or your desire to have settled by means of a written grievance. The following procedures are aimed at achieving mutual agreement for the settlement of a dispute.

- 1) All grievances must be presented to us in written form. Any written grievance between you and us or between you and a hospital must be dealt with through this grievance procedure.
- 2) Any written grievance must contain the words "THIS IS A GRIEVANCE" or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure.
- 3) A grievance must be filed by submitting the complete details in writing to Sentinel Security Life Insurance Company, c/o Grievance Review, P.O. Box 16960, Clearwater, FL 33766-6960.
- 4) Each grievance is processed within a maximum of 60 days after it is received by us. Each level of the grievance process is handled by a person with problem-solving authority. A Physician, other than your primary care physician, must be involved in reviewing any medically related grievances.
- 5) If a grievance is found to be valid, corrective action will be taken promptly.

- 6) All concerned parties are to be notified about the result of a grievance.
- 7) You have the right to appeal to the Department of Insurance after first completing our grievance process.
- 8) Any meeting with you must be scheduled at a location or in a manner which is convenient and will not necessitate excessive travel or undue hardship.
- 9) The time for filing a grievance is limited to a period of not more than one year from the date of occurrence.

Sentinel Security Life Insurance Company

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

Toll-free **888-510-0668**

Fax **800-719-1264**

www.sentinellife.org

This Page Intentionally Left Blank

Agent checklist for completing the Medicare Select Application

This packet contains the following forms needed to complete a Medicare Select application. Please tear out the **application** and all pages marked “**RETURN TO COMPANY**” and leave the remaining pages with the applicant(s). Please review the following information carefully and complete all needed forms:

- ☐ Application for Medicare Supplement/Select (Form SSLMED10-LA Rev 05/10)
 - If the applicant(s) is applying during Open Enrollment or a Guaranteed Issue period Section 4 is not required to be completed
 - Section 5 should only be completed if the applicant(s) would like his/her payments to be deducted automatically from their checking/savings account. This option only applies if premiums are paid monthly.
- ☐ Agent Certification (Form SSLMED-CERT-OT Rev 05/10) - This form must be signed by the agent and by the applicant(s)
- ☐ Calculate Your Premium – This form is used in coordination with the Outline of Coverage to calculate the correct premium. This form must be returned with the application
- ☐ Fax Transmittal – Follow the instructions on this form only if the applicant(s) elects to pay premiums using ACH and you would like to fax the underwriting documents instead of mailing them
- ☐ Authorization to Release Confidential Medical Information (Form SSLHIPAA2-OT) – Must be completed only if applying outside Open Enrollment or a Guaranteed Issue period. If a husband and wife are both applying for coverage on the same application then both must sign the form
- ☐ Acknowledgement of Receipt of Medicare Select Disclosure Statement (Form SSLMED-SEL-ACK-OT) - Signed acknowledgement must be submitted with Medicare Select applications
- ☐ Notice to Applicant Regarding Replacement of Medicare Supplement Insurance or Medicare Advantage (Form SSLMED-REP-OT) - This form must be completed if any replacement is involved. One signed copy must be returned to the Administrative Office and the other signed copy must be left with the applicant(s)
- ☐ Medicare Supplement/Select Initial Premium Receipt (Form SSLMED-100-OT) – This form must be left with the applicant(s) and the full modal premium is required with all applications
- ☐ Medicare Select Disclosure Statement (Form SSLMED-SEL10-DISC-OT) - Must be left with the applicant(s) for Medicare Select applications

Please note, you are also required to provide the applicant(s) with the following items:

- ☐ Medicare Select Hospital Network Listing
- ☐ Guide to Health Insurance for People with Medicare
- ☐ Genetic Testing Form (Form SSL-GENTEST-LA)
- ☐ Outline of Coverage (Form SSLMED-OTLN10-OT Rev 05/10)

Premiums and Policy Fee

Utilize the Outline of Coverage to determine premiums:

- Determine ZIP code where the client resides and find the correct rate page for that ZIP code
- Determine Plan
- Determine if non-tobacco or tobacco
- Find Age/Gender - Verify that the age and date of birth are the exact age as of the application date, his will be your base monthly premium
- Use the Calculate Your Premium form to adjust the monthly premium for different modes and to add the policy fee

There will be a one-time application fee of \$25.00 that must be collected with each applicant's initial payment. For a husband and wife written on the same application, \$50 in fees must be collected. This will not affect the renewal premiums and the application fee doesn't apply in WA.

Mailing Address

Sentinel Security Life Insurance Company
P.O. Box 16960
Clearwater, FL 33766-6960

Overnight/Express Address

Sentinel Security Life Insurance Company
2536 Countryside Boulevard, Suite 501
Clearwater, FL 33763

FAX Number for New Business - ACH Applications 1-800-719-1264

Sentinel Security Life Insurance Company

Administrative Office

P.O. Box 16960

Clearwater, FL 33766-6960

Application For Medicare Supplement Coverage

PLAN INFORMATION (to be completed by **Producer**)

NOTE: For ALL sections, ONLY complete the Applicant B information if to be insured.

<u>APPLICANT</u>		<u>APPLICANT B</u>	
Medicare Supplement Plan	Medicare Select Plan (not available in all states)	Medicare Supplement Plan	Medicare Select Plan (not available in all states)
<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> N	<input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> N	<input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> N	<input type="checkbox"/> C <input type="checkbox"/> D <input type="checkbox"/> F <input type="checkbox"/> N
Requested Effective Date		Requested Effective Date	
Mail Policy To: <input type="checkbox"/> Insured <input type="checkbox"/> Agent		Mail Policy To: <input type="checkbox"/> Insured <input type="checkbox"/> Agent	
Premium Collected \$		Premium Collected \$	
Renewal \$		Renewal \$	
Renewal Mode A, S, Q,ACH (direct monthly not available)		Renewal Mode A, S, Q,ACH (direct monthly not available)	

1. PLEASE READ THE FOLLOWING CAREFULLY AND ANSWER ALL QUESTIONS COMPLETELY.

Applicant	Applicant B
Name (First/Middle/Last)	Name (First/Middle/Last)
Residence Address	Residence Address
City	City
State ZIP	State ZIP
Mailing Address (if different from residence address)	Mailing Address (if different from residence address)
City	City
State ZIP	State ZIP
Home Phone No (_____)_____ (area code)	Home Phone No (_____)_____ (area code)
Current Age _____ Date of Birth _____ mo/day/ yr	Current Age _____ Date of Birth _____ mo/day/ yr
Male <input type="checkbox"/> Female <input type="checkbox"/> State of Birth _____	Male <input type="checkbox"/> Female <input type="checkbox"/> State of Birth _____
Social Security No	Social Security No
Medicare Health Insurance Card Number (if known)	Medicare Health Insurance Card Number (if known)
E-mail Address	E-mail Address
Height Weight Ft _____ In _____ Lbs _____	Height Weight Ft _____ In _____ Lbs _____

2. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS.			
<p>1. Have you received a copy of the Guide to Health Insurance for People with Medicare and the Outline of Coverage?</p> <p>To the Best of Your Knowledge:</p> <p>1. Are you covered under Medicare Part A? If "YES," what is your Part A effective date? _____ / _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Applicant Applicant B </div> </p> <p> If "NO," what is your eligibility date? _____ / _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Applicant Applicant B </div> </p> <p>2. Are you covered under Medicare Part B? If "YES," what is your Part B effective date? _____ / _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Applicant Applicant B </div> </p> <p> If "NO," indicate date you plan to enroll. _____ / _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Applicant Applicant B </div> </p> <p>3. Did you turn age 65 in the last six months?</p> <p>4. Did you enroll in Medicare Part B in the last six months? If "YES," indicate your effective date. _____ / _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Applicant Applicant B </div> </p>		<p>Applicant</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Applicant B</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare supplement insurance policy or certificate, or that you had certain rights to buy such a policy or certificate, you may be guaranteed acceptance in one or more of our Medicare supplement plans. Please include a copy of the notice from your prior insurer with your application. PLEASE ANSWER ALL QUESTIONS. Please mark "YES" or "NO" with an "X" to the questions below.</p>			
3. FOR YOUR PROTECTION, the National Association of Insurance Commissioners requests that we ask the following questions about insurance policies or certificates you may have.			
<p>To the Best of Your Knowledge:</p> <p>1. Are you applying during a guaranteed issue period? (NOTE: If the answer above is "YES," please attach proof of eligibility.)</p> <p>2. Do you have another Medicare supplement or Medicare select insurance policy or certificate in force? (a) If "YES," with what company, and what plan do you have?</p>		<p>Applicant</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Applicant B</p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>
<p>Applicant</p>		<p>Applicant B</p>	
Name of Company		Name of Company	
Policy/Certificate Number		Policy/Certificate Number	
Plan		Plan	
Issue Date / /		Issue Date / /	
<p>(b) If "YES," do you intend to replace your current Medicare supplement policy/certificate with this policy? (c) If "YES," indicate termination date. _____ / _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Applicant Applicant B </div> </p> <p>(d) If "YES," have you received a copy of the replacement notice?</p> <p>If you have had any other Medicare plan coverage as referenced below, not to include Medicare supplement, please complete questions (a-g) below. If not, skip to question #4.</p> <p>3. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO), fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START _____ END _____ / START _____ END _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Applicant Applicant B </div> </p> <p>(a) If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare supplement policy?</p> <p>(b) If "YES," have you received a copy of the replacement notice?</p> <p>(c) Reason for termination/disenrollment? _____ / _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Applicant Applicant B </div> </p> <p>(d) Planned date of termination/disenrollment? _____ / _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Applicant Applicant B </div> </p>		<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>	<p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p> <p>Yes <input type="checkbox"/> No <input type="checkbox"/></p>

(e) Was this your first time in this type of Medicare plan? (f) Did you drop a Medicare supplement or Medicare select policy/certificate to enroll in this Medicare plan? (g) Is your former Medicare supplement or Medicare select policy/certificate still available? 4. Have you had coverage under any other health insurance within the past 63 days? (For example, an employer, union, or individual non-Medicare supplement plan.) (a) If "YES," with what company and what kind of policy/certificate? (List below.)		Applicant 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 <input type="checkbox"/>	Applicant B 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 <input type="checkbox"/>
Applicant		Applicant B	
Name of Company	Kind of Policy/Certificate	Name of Company	Kind of Policy/Certificate
(b) What are your dates of coverage under the other policy/certificate? If you are still covered under this plan, leave "END" blank. START _____ END _____ / START _____ END _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Applicant Applicant B </div>			
(c) Reason for termination/disenrollment? _____ / _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Applicant Applicant B </div>			
(d) Planned date of termination/disenrollment? _____ / _____ <div style="display: flex; justify-content: space-between; width: 100%;"> Applicant Applicant B </div>			
5. Are you covered for medical assistance through the state Medicaid program? (NOTE TO APPLICANT: If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer "NO" to this question.) If "YES," (a) Will Medicaid pay your premiums for this Medicare supplement policy? (b) Do you receive any benefits from Medicaid OTHER THAN payment toward your Medicare Part B premium?		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 <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Producers shall list any other health insurance policies/certificates they have sold to the applicant. (a) List policies/certificates sold which are still in force.			
Applicant		Applicant B	
Name of Company		Name of Company	
Policy/Certificate Number		Policy/Certificate Number	
Description of Benefits		Description of Benefits	
Effective Date of Coverage		Effective Date of Coverage	
(b) List policies/certificates sold in the past five (5) years which are no longer in force.			
Applicant		Applicant B	
Name of Company		Name of Company	
Policy/Certificate Number		Policy/Certificate Number	
Description of Benefits		Description of Benefits	
Effective Date of Coverage		Effective Date of Coverage	

If you are applying during Open Enrollment or a Guaranteed Issue period, SKIP SECTION 4 and GO TO SECTION 5.

4. PLEASE ANSWER ALL OF THE FOLLOWING QUESTIONS. Make sure all questions are answered by each applicant. If either you or Applicant B answer “YES” to any of the following questions 2-15, that person is not eligible for coverage.

	Applicant Yes <input type="checkbox"/> No <input type="checkbox"/>	Applicant B Yes <input type="checkbox"/> No <input type="checkbox"/>
1. Have you used tobacco in any form in the past 12 months?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. Are you currently hospitalized, confined to a nursing facility, receiving hospice or home health care; or, are you bedridden or confined to a wheelchair?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. Have you been diagnosed with emphysema, Chronic Obstructive Pulmonary Disease (COPD) or other chronic pulmonary disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. Have you been diagnosed with Parkinson’s Disease, Systemic Lupus, Myasthenia Gravis, Multiple or Lateral Sclerosis, Osteoporosis with fractures, Cirrhosis or kidney disease requiring dialysis?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. Have you been diagnosed with Alzheimer’s Disease, Senile Dementia, or any other cognitive disorder?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
6. Have you been diagnosed with or treated for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
7. If you have diabetes, do you have any of the following conditions: diabetic retinopathy, peripheral vascular disease, neuropathy, any heart condition (including high blood pressure) or kidney disease? If you do not have diabetes, this question should be answered “NO”.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
8. Do you have diabetes that has ever required more than 50 units of insulin daily?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
9. Within the past two years have you been treated for or been advised by a physician to have treatment for internal cancer, alcoholism or drug abuse, mental or nervous disorder requiring psychiatric care or have you had any amputation caused by disease?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
10. Within the past two years have you been treated for or been advised by a physician to have treatment for heart attack, heart, coronary or carotid artery disease (not including high blood pressure), peripheral vascular disease, congestive heart failure or enlarged heart, stroke, transient ischemic attacks (TIA) or heart rhythm disorders?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
11. Within the past two years have you been treated for degenerative bone disease, crippling/disabling or rheumatoid arthritis or have you been advised to have a joint replacement?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
12. Have you been advised by a physician that surgery may be required within the next 12 months for cataracts?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
13. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
14. Have you been hospital confined three or more times in the last two years?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
15. Have you had an organ transplant or been advised by a physician to have an organ transplant?	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
16. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If “YES,” please list the drug and the condition in the following table.	Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

Applicant (please attach a separate sheet if needed)		Applicant B (please attach a separate sheet if needed)
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

5. BILLING INFORMATION**I would like my monthly direct payment to come from my (check one) on the _____ day of the month:**☐ Checking **Please attach a voided check** ☐ Savings **Please ask your financial institution to verify that this EFT will be accepted and that the information below is correct.**

Financial Institution Name:

Phone #:

Financial Institution Address:

Transit Routing #:

Account #:

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

Signature as it appears on financial institution records_____
Print name of account owner (if other than proposed insured)_____
Date

6. PLEASE READ AND SIGN BELOW

IMPORTANT STATEMENTS TO BE READ BY APPLICANT

- You do not need more than one Medicare supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverage.
- You may be eligible for benefits under Medicaid and may not need a Medicare supplement policy.
- If, after purchasing the policy, you become eligible for Medicaid, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for, and have enrolled in a Medicare supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

I wish to apply for a Medicare supplement insurance policy. I represent that my answers and statements on this application are true and complete. I understand that, (a) upon acceptance of the completed application, each applicant will receive a separate policy; (b) my policy benefits can start no earlier than my Medicare effective date, my first month's premium has been received and/or processed and my application has been approved by Sentinel Security Life Insurance Company.

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.

I understand the Company may obtain an investigative consumer report on me and a telephone interview may be necessary to verify or supplement information given to the Company on this application. I understand my right to request to be interviewed and that I may request a copy of the report if no personal interview is conducted. A photocopy of this form will be as valid as the original; this Authorization and Acknowledgment will be valid for 24 months after it is signed.

Dated at _____, on _____, _____
City State Month Day Year Applicant's Signature

Dated at _____, on _____, _____
City State Month Day Year Applicant B's Signature (if applying)

Premium Must Accompany Application

I/We certify that during an interview with the proposed applicant, I/we have truly and accurately recorded in the application the information supplied by the applicant.

(Signature of Licensed Producer)

(Signature of Licensed Producer)

PRODUCER NUMBER / (STAMP)

PRODUCER NUMBER / (STAMP)

ADDITIONAL INFORMATION: PART 4 - CON'T. HEALTH /MEDICAL QUESTIONS - Question #15		
Applicant (please attach a separate sheet if needed)		Applicant B (please attach a separate sheet if needed)
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	
	Medication Name (copy off pharmacy label)	
	Date Originally Prescribed	
	Frequency and Dosage	
	Diagnosis/Condition	

SECTION FOR ADDITIONAL COMMENTS	
Applicant (please attach a separate sheet if needed)	Applicant B (please attach a separate sheet if needed)

This Page Intentionally Left Blank

I the undersigned insurance agent certify;

THAT, I have taken an application for:

Primary Insured:

Medicare Supplement

Medicare Select

- ☐ Plan A
☐ Plan B
☐ Plan C
☐ Plan D
☐ Plan F
☐ Plan N

- ☐ Plan C
☐ Plan D
☐ Plan F
☐ Plan N

Spouse:

Medicare Supplement

Medicare Select

- ☐ Plan A
☐ Plan B
☐ Plan C
☐ Plan D
☐ Plan F
☐ Plan N

- ☐ Plan C
☐ Plan D
☐ Plan F
☐ Plan N

Offered by **SENTINEL SECURITY LIFE INSURANCE COMPANY**,

to _____
(Applicant(s)),

THAT, I have explained the provisions of the policy being applied for, including specifically, all the different benefits, exceptions and limitations of the plan.

THAT, I am a licensed agent of this insurance company and have given a company receipt for an initial premium in the amount of

\$_____ which has been paid to me by

☐ Check ☐ Money Order ☐ ACH (Check appropriate method of payment)

THAT, I have clearly explained any benefits of this plan are a supplement to any benefits that the applicant may be entitled to receive from the Medicare Program of the Federal Government.

THAT, I have not made any representation to the applicant that there is any endorsement whatsoever by the Social Security Administration or the Centers for Medicare and Medicaid Services in connection with this insurance policy being applied for.

Date

Signature of Agent

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

Name of Agency

Signature of Applicant

Address of Agent / Agency

Signature of Spouse, if applying

Phone Number

Authorization to Release Confidential Medical Information

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

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

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

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

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

Name of Proposed Insured (please print)

Name of Proposed Insured B (please print)

Signature of Proposed Insured

Signature of Proposed Insured B

DATE

DATE

Medicare Supplement Plan _____

Before you begin: If you're not in your open enrollment or guarantee issue period, please go to page 2 to determine your eligibility for coverage.

Steps	Example Rate displayed is used for calculation purposes only.	Applicant's Premium	Applicant B's Premium
Premium Write in your Medicare supplement plan's premium from the Outline of Coverage table.	\$128.52		
Payment Options To determine other payment schedules, multiply your monthly premium by: 3 to pay four times a year (quarterly) 6 to pay twice a year (semi-annually) 12 to pay once a year (annually)	<p>\$128.52 Monthly Payment</p> <p>\$385.56 Quarterly Payment</p> <p>\$771.12 Semi-Annual Payment</p> <p>\$1,542.24 Annual Payment</p>		
Enrollment/Policy Fee There is a one-time application fee of \$25. This will be collected with your initial payment and will NOT affect your renewal premium.	<p>$\\$128.52 + \\$25.00 = \\$153.52$</p> <p>Example shows initial payment (monthly schedule).</p>		

Height and Weight Charts

Eligibility

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

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



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

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

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

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

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

STEP 2 – FAX THE FOLLOWING ITEMS TO THE DEDICATED LINE FOR ACH PAYMENTS AT (800) 719-1264

- 1) ACH fax transmittal cover sheet on the back of this form
- 2) Medicare Supplement Application and other required forms including authorization for EFT

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

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



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

FAX TRANSMITTAL

FOR USE WITH EFT MONTHLY PREMIUM APPLICATIONS ONLY

1-800-719-1264

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

Please complete the following information:

Total number of pages being faxed including this cover sheet _____

Producer Name _____

Producer Number or SSN _____

Producer Phone Number _____

Producer Fax Number _____

Comments _____

This communication and any attachments transmitted with it are confidential and are solely for the use of the addressee. It may contain material that is legally privileged, proprietary or subject to copyright belonging to Sentinel Life Insurance Company and its affiliates. It may be subject to protection under federal or state law. If you are not the intended recipient, you are notified that any use of this material is strictly prohibited. If you received this transmission in error, please contact the sender immediately by telephone, at the number shown above. We will arrange for you to return the original material to us via the US Postal Service and if requested, we will reimburse you for such expense.

SENTINEL SECURITY LIFE INSURANCE COMPANY

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

Notice to Applicant regarding replacement of Medicare supplement insurance or Medicare Advantage
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement insurance or Medicare Advantage and replace it with a policy to be issued by Sentinel Security Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT

I HAVE REVIEWED YOUR CURRENT MEDICAL FOR HEALTH INSURANCE COVERAGE. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

☐ Other. (Please Specify) _____

1. State laws provide that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

2. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for any company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent / Broker / Other Representative_____
Print Name and Address of Issuer / Agent / Broker_____
Signature of Applicant_____
Signature of Spouse, if applying_____
Date

I, the applicant, acknowledge receipt of the following information:

- ☐ Outline of Coverage and Premium Information for the Medicare SELECT Plan for which I am applying;
- ☐ Description of Network Hospitals; and
- ☐ Medicare SELECT Disclosure Statement.

I also understand the following:

- ☐ The Part "A" benefits of the Sentinel Security Life Medicare SELECT plan may be restricted if I receive services in a hospital that is not a Network Provider.
- ☐ Sentinel Security Life Insurance Company does not advise the purchase of a Medicare SELECT policy if I live more than a reasonable distance for me to travel to receive inpatient health services as reflected by usual and customary travel patterns of my area from the Network Hospital; unless the Network Hospital is the closest hospital to me which offers this level of service.
- ☐ I have the right to purchase any non-restricted Medicare Supplement insurance product offered by Sentinel Security Life Insurance Company.

I acknowledge receipt of the above information and I understand the information above including the restrictions of the Medicare SELECT Plan.

Applicant's Signature

DATE

SENTINEL SECURITY LIFE INSURANCE COMPANY

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

Notice to Applicant regarding replacement of Medicare supplement insurance or Medicare Advantage
SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare supplement insurance or Medicare Advantage and replace it with a policy to be issued by Sentinel Security Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare supplement coverage is a wise decision, you should terminate your present Medicare supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT

I HAVE REVIEWED YOUR CURRENT MEDICAL FOR HEALTH INSURANCE COVERAGE. To the best of my knowledge, this Medicare supplement policy will not duplicate your existing Medicare supplement or, if applicable Medicare Advantage coverage because you intend to terminate your existing Medicare supplement coverage or leave your Medicare Advantage plan. The replacement policy is being purchased for the following reason(s) (check one):

- ☐ Additional benefits.
- ☐ No change in benefits, but lower premiums.
- ☐ Fewer benefits and lower premiums.
- ☐ My plan has outpatient prescription drug coverage and I am enrolling in Part D.
- ☐ Disenrollment from a Medicare Advantage plan. Please explain reason for disenrollment.

☐ Other. (Please Specify) _____

1. State laws provide that your replacement policy or certificate may not contain new pre-existing conditions, waiting periods, elimination periods or probationary periods. The insurer will waive any time periods applicable to pre-existing conditions, waiting periods, elimination periods or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

2. If, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for any company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Agent / Broker / Other Representative_____
Print Name and Address of Issuer / Agent / Broker_____
Signature of Applicant_____
Signature of Spouse, if applying_____
Date

SENTINEL SECURITY LIFE INSURANCE COMPANY

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

INVESTIGATIVE CONSUMER REPORT NOTICE TO APPLICANT

Federal law requires that notice of investigation be given to persons applying for insurance. In making this application for insurance to Sentinel Security Life Insurance Company (the Company), it is understood that an investigative consumer report may be prepared whereby information is obtained through personal interviews with your neighbors, friends, or others with whom you are acquainted. This inquiry includes information as to your character, general reputation, personal characteristics, and mode of living (the term "mode of living" does not relate directly or indirectly to the sexual orientation of any proposed insured). You may request to be interviewed for the consumer report. You may, upon written request, be informed whether or not the report was ordered, and if so, the name and address of the consumer reporting agency which made the report. Upon proper identification, you have the right to inspect and/or receive a copy of the report from the consumer reporting agency. You have the right to make a written request to the Company within a reasonable period of time to receive additional detailed information about the nature and scope of the investigation. Write to: Underwriting Department, Sentinel Security Life Insurance Company, P.O. Box 16960, Clearwater, Florida, 33766-6960.

MEDICAL INFORMATION BUREAU DISCLOSURE NOTICE

Information regarding your insurability will be treated as confidential. Sentinel Security Life Insurance Company (the Company) or its reinsurer(s) may, however, make a brief report thereon to the MIB, Inc., formerly known as Medical Information Bureau, a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another MIB member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information about you in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information in your file. Please contact MIB at 866-692-6901 (TTY 866-346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of MIB's information office is 50 Braintree Hill Park, Suite 400, Braintree, Massachusetts 02184-8734.

The Company or its reinsurer(s) may also release information from its file to other insurance companies to whom you may apply for life or health insurance, or to whom a claim for benefits may be submitted. Information for consumers about MIB may be obtained on its website at www.mib.com.

MEDICARE SUPPLEMENT / SELECT INITIAL PREMIUM RECEIPT**MAKE CHECK PAYABLE TO: SENTINEL SECURITY LIFE INSURANCE COMPANY**

Received from _____ (Proposed Insured) an application for a Medicare Supplement Policy with Sentinel Security Life Insurance Company (the Company), Salt Lake City, Utah and \$ _____ for the initial premium. In the event the application is not accepted by the Company, the above amount will be refunded. No obligation is incurred by the Company unless said application is approved by the Company at its Administrative Office and a policy is issued.

Agent's Name (please print) _____

Agent's Signature _____

Date _____

UNDERSTANDING MEDICARE SELECT

Offered and underwritten by Sentinel Security Life Insurance Company. Medicare SELECT supplement insurance plans offer attractive premiums in exchange for your commitment to use Network Hospitals whenever possible.

NETWORK HOSPITAL RESTRICTIONS

When you require health care services in a Hospital on an inpatient basis, you may choose any Hospital you wish. However, benefits under the Inpatient Hospital Confinement Deductible Benefit provision are conditioned on whether you use a Participating Hospital or a Non-Participating Hospital. If you use the services of a Participating Hospital, the Medicare Part A inpatient Hospital deductible amount will be waived by the Hospital. If you use the services of a Non-Participating Hospital, the Hospital will not waive, and we will not pay, the Medicare Part A inpatient Hospital deductible amount, unless:

- (1) you are hospitalized for symptoms requiring Emergency Care or hospitalization is immediately required for an unforeseen Sickness, Injury or condition;
- (2) it is not reasonable for you to obtain services through a Participating Hospital; or
- (3) you require covered services that are not available through a Participating Hospital.

These Network Hospital Restrictions apply only to the Inpatient Hospital Confinement Deductible Benefit. These restrictions do not apply to any other benefit in your policy.

We do not supervise, control or guarantee the health care services of any Hospital, whether it is a Participating Hospital or a Non-Participating Hospital.

EMERGENCY CARE

Benefits will be paid at any Medicare-approved hospital when you require emergency care and it is not reasonable to obtain such care from a network hospital.

Emergency Care means care needed immediately because of a Sickness or Injury of sudden and unexpected onset. Emergency Care is available twenty-four (24) hours per day and seven (7) days per week.

REFERRALS

There are no restrictions on referrals to other hospitals if you obtain prior certification from your Physician or health care provider that the services are not available at a Network Hospital. Additionally, there are no restrictions on referrals for outpatient providers regardless of whether that provider is in the service area.

AVAILABILITY OF OTHER MEDICARE SUPPLEMENT PLANS

Sentinel Security Life Insurance Company offers Medicare Supplement Plans A, B, C, D and F. Any of these plans are available for you to purchase now or at any time you wish to convert from a Medicare SELECT plan. You also have the right (but are not required) to convert to any Medicare Supplement policy Sentinel Security Life has available with comparable or lesser benefits if (1) the Medicare SELECT program is discontinued, or (2) THE AGREEMENTS BETWEEN Sentinel Security Life and all Network Hospitals in your service area are terminated.

You may also convert your policy if you move outside the Service Area and your new residence is not within a reasonable travel distance of a Network Hospital. Although you are not required to convert your policy in this instance, you will be responsible for Payment of the Medicare Part A inpatient Hospital deductible if you use a Non-Network Hospital for scheduled admissions.

If you choose to convert your policy to a Medicare Supplement policy, you will not need to provide evidence of insurability if your policy has been in force for at least six (6) months.

QUALITY ASSURANCE

Each Network Hospital within the Service Area has appropriate state licensing and is Medicare certified. All hospitals within the network have an appropriate mix of physician specialties for covered services provided by the hospital. When using a Network Hospital you're assured that the care you receive meets or exceeds the acceptable standards of quality for the hospital industry.

GRIEVANCE PROCEDURE

Sentinel Security Life strives to provide quality administration and services to you through an excellent customer service program designed to provide information to you, handle complaints and attempt to satisfy your concerns. You are encouraged to bring complaints to Our attention by contacting Sentinel Security Life's Customer Service program in writing or by phone: [Administrative Office at P.O. Box 16960, Clearwater, Florida, 33766-6960; or telephone 1-800-247-1423].

For settlement of disputes that have not been successfully resolved through Sentinel Security Life's customer service program, or that you desire to have settled by means of a written Grievance, the following formal Grievance procedures have been established.

If while staying at a Network Hospital, you have a complaint regarding hospital services being provided, you may contact Sentinel Security Life's Administration Office by phone [(1-800-247-1423)] to express the complaint. We will relay the complaint to the Network Hospital's Administration on an immediate basis for prompt resolution.

The following Grievance Procedures are designed to achieve mutual agreement for settlement of disputes:

- (1) All grievances must be presented to us in written form. Any written grievance between you and us or between you and a hospital must be dealt with through this grievance procedure.
- (2) Any written grievance must contain the words "THIS IS A GRIEVANCE" or other words that clearly state that the intention of the written communication is to serve as a written grievance to be handled according to this procedure.
- (3) A grievance must be filed by submitting the complete details in writing to Sentinel Security Life Insurance Company, c/o Grievance Review, [P.O. Box 16960, Clearwater, FL 33766-6960].
- (4) Each grievance is processed within a maximum of 60 days after it is received by us. Each level of the grievance process is handled by a person with problem-solving authority. A Physician, other than your primary care physician, must be involved in reviewing any medically related grievances.
- (5) If a grievance is found to be valid, corrective action will be taken promptly.
- (6) All concerned parties are to be notified about the result of a grievance.
- (7) You have the right to appeal to the Department of Insurance after first completing our grievance process.
- (8) Any meeting with you must be scheduled at a location or in a manner which is convenient and will not necessitate excessive travel or undue hardship.
- (9) The time for filing a grievance is limited to a period of not more than one year from the date of occurrence.

In order to help you evaluate the benefits in each Medicare SELECT and Medicare Supplement policy Sentinel Security Life offers; please review the appropriate Outline of Coverage.

YOUR RIGHTS REGARDING THE RELEASE AND USE OF GENETIC INFORMATION

Sentinel Security Life Insurance Company is prohibited by law from requiring any applicant to undergo genetic testing or to be subjected to questions relating to genetic information.



Sentinel Security Life

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

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

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

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

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

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

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

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

Revised 02-2011