APPLICATION FOR INDIVIDUAL LIFE INSURANCE Print - Use Black Ink	**SENTINEL SECURITY LIFE INSURANCE COMPANY** **PO Box 27248** **Salt Lake City, Utah 84127-0248** **Phone: 1-800-247-1423**	*Home Office Use Only*

1. PROPOSED INSURED:

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

2.a CURRENT ADDRESS: | **2.b MAILING/BILLING ADDRESS (if different than 2.a):**

Street	How Long?		Street or Box No.		
City	State	Zip	City	State	Zip

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

3. EMPLOYMENT:

Job Title	Employer Name	Employer Address

4. BENEFICIARY:

Primary Beneficiary:	Phone Number ( )	Relationship	
Address of Primary Beneficiary	City	State	Zip
Contingent Beneficiary:	Phone Number ( )	Relationship	
Address of Contingent Beneficiary	City	State	Zip

5. OWNER:

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

6. AUTOMATIC PREMIUM LOAN:

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

7. HEALTH INFORMATION:

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

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

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

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

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

Yes No

1. Is the Proposed Insured currently: bedridden, confined to a nursing or correctional facility, receiving hospice or home health care, received or been advised to receive an organ or tissue transplant, or been hospitalized within the last 3 months?……………………………………………………………………
2. Does the Proposed Insured currently use a wheelchair due to a chronic illness or disease, or require assistance with activities of daily living such as bathing, dressing, eating or toileting?………………………………………
3. Has the Proposed Insured been medically treated or diagnosed by a licensed member of the medical profession, or taken medication for:
   a. Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or the Human Immunodeficiency Virus (HIV)?……………………………………………………………………
   b. Alzheimer's, dementia, Lou Gehrig's Disease (ALS), Huntington's Disease, or **prior to age 25**, Cerebral Palsy, Down's Syndrome, spina bifida, cystic fibrosis, mental retardation, or muscular dystrophy? ………………………………
   c. A terminal medical condition that would reasonably be expected to cause death within the next **12 months**?…………
4. Has the Proposed Insured, within the past **12 months,** been advised to have a diagnostic test, surgery, dialysis, home health care or hospitalization which has not yet been **started, completed or for which results are not known?**…………

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

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

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

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

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

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

8. POLICY AND PREMIUM INFORMATION:

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

New Vantage® II **New Vantage® III**

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

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

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

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

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

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

10. OTHER INSURANCE:

Yes No

a. Does the Proposed Insured currently have any life insurance or annuity in force?
b. Will insurance applied for in this Application replace, reduce coverage or modify premiums paid for any existing life insurance or an annuity in force?

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

c. Are any other applications pending with other companies?

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

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

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

Financial Institution ____________________ Routing No. ____________ Account No. ____________

I would like my **initial** payment to come from my (check one): **Visa** **Master Card** **Discover**
(Initial premium only)
Credit Card Account No. ____________ Exp. Date (mo/yr) ___/___ Name on Card ____________
Address (must match statement) ____________ City, State, Zip ____________

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

____________ Date

____________ Signature of Account Holder

12. AUTHORIZATION FOR CONSUMER REPORT AND ACKNOWLEDGMENT:

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

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

Signed At ____________ City ____________ State

____________ Signature of Proposed Insured (or Parent or Guardian of Minor Child)

____________ Agent ____________ Date

____________ Signature of Owner if Different

13. AGENTS DISCLOSURE:

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

Licensed Agent ____________

Agent Signature ____________

Agent's No. ____________

Date ____________

Split Agent Name ____________

Split Agent Number ____________

Split Percentage ____________

Send policy to: Agent Insured

AGENT NOTES

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