



## AGENT'S REPLACEMENT REPORT

(Must be completed and submitted with the application in the event of replacement)

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

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

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Agent's Signature

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Date

340-351

4/07(✓)



340-351

DOC SCAN

**Sentry Life Insurance Company**  
 1800 North Point Drive  
 P.O. Box 8018  
 Stevens Point, WI 54481-8028

800-533-7827  
 715-346-7283 Fax



## REPLACEMENT NOTICE

### ASK QUESTIONS – IT'S YOUR MONEY – GET THE FACTS

Whether it is to your advantage to replace or change your existing insurance or annuity program, only you can decide. It is in your best interest to obtain adequate information in order to compare relatively short and long range costs and benefits before a final decision is made.

The producer or insurance company assisting you with this new purchase must notify your existing producer or company so that they may prepare a detailed, current statement concerning your existing program for your comparison. Statements and illustrations should not, however, be used as the sole basis to compare policies or contracts. We want you to understand the effects of replacements before you make your purchase decision, and ask that you review the statements listed under "Items to Consider."

### EXISTING INSURANCE WHICH MAY BE REPLACED OR CHANGED

Full Name of Insurance Company Including Home Office Location	Policy or Contract Number *	Insured
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Surrender Charge of Policy Being Replaced \_\_\_\_\_ % and \$ \_\_\_\_\_

Sales Charge of Policy Being Purchased (if applicable) \$ \_\_\_\_\_

New Surrender Period and Surrender Charges of Policy Being Purchase.

YEARS										
% CHARGE										

YEARS										
% CHARGE										

\* If a number has not been assigned by the existing insurer, indicate alternative identification, such as an application or receipt number.



## ITEMS TO CONSIDER

1. Due to a possible change in insurability status (health, occupation or high risk recreational activities) you might be denied new coverage, or the premium may be higher than a standard premium.
2. The Incontestability and Suicide Clause time periods would probably begin anew in a new policy. This could possibly result in a claim being denied that might otherwise have been paid under an existing policy or contract.
3. Your present insurance company may be able to modify your existing plan on terms which may be more favorable for you than completely replacing it with a new policy or contract.
4. Don't terminate or alter your existing policy until after the new policy has been delivered to you and accepted by you.
5. If you terminate your existing policy, you may incur surrender charges and/or penalties. The new policy you are purchasing may have a new surrender charge period and/or sales charges.
6. There may be tax consequences in replacing an existing policy. Is there a benefit from favorable "grandfathered" treatment of the old policy under the federal tax code? Is this transaction a "tax free" exchange? See your tax advisor for specific tax advice regarding the proposed transaction.
7. Take your time in making your decision about purchasing the new policy. Gather all information about the new policy and compare it to your old policy. Remember, you do not have to make a decision during the first meeting with your sales person.
8. REMEMBER: Following receipt of a new life insurance policy or annuity contract you should immediately examine its contents. If you are not satisfied with it for any reason, you have the right to return it within the thirty (30) day "examination period" to the insurer at its home office or branch office or to the producer through whom it was purchased, for a full refund of premium. If you do return the policy or contract, you should request a dated receipt indicating that it was returned.

### DID YOU READ THE “ITEMS TO CONSIDER”?

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Applicant's Signature	Date
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Applicant's Name(printed)

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Address

City, State, Zip Code

Telephone Number \_\_\_\_\_

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Producer's Signature	Date
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Producer's Name (printed) and License Number

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Address \_\_\_\_\_

City, State, Zip Code

Telephone Number \_\_\_\_\_

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Surrender Charge of Policy Being Replaced \_\_\_\_\_ % and \$\_\_\_\_\_

Sales Charge of Policy Being Purchased (if applicable) \$\_\_\_\_\_

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YEARS										
% CHARGE										

YEARS										
% CHARGE										

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### DID YOU READ THE “ITEMS TO CONSIDER”?

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Applicant's Signature	Date
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Applicant's Name(printed)

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Address

City, State, Zip Code

Telephone Number \_\_\_\_\_

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Producer's Signature	Date
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Producer's Name (printed) and License Number

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Address \_\_\_\_\_

City, State, Zip Code

Telephone Number \_\_\_\_\_



## U.S. Military Personnel Life Insurance Disclosure and Acknowledgement

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

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

- \_\_\_\_\_ I do not reside on any U.S. Military Installation, Federal Land or other Federally Controlled Property.
- \_\_\_\_\_ I am aware that subsidized life insurance is available to me as a member of the Armed Forces from the Federal Government under the Servicemembers' Group Life Insurance program (also referred to as "SGLI"), under subchapter III of chapter 19 of title 38, United States Code;
- \_\_\_\_\_ I am aware of the amount of insurance coverage available to me under the SGLI program, together with the costs to me as a member of the Armed Forces for such coverage and prefer to purchase Life Insurance Protection from Sentry Life Insurance Company.

SGLI Death Benefit Available: \$\_\_\_\_\_ SGLI Premium: \$\_\_\_\_\_

- \_\_\_\_\_ The Life Insurance Policy that I am applying for is being offered by Sentry Life Insurance Company and is not offered or provided by the Federal Government, and the Federal Government has in no way sanctioned, recommended, or encouraged the sale of the life insurance product being offered.
- \_\_\_\_\_ I have been informed that if the life policy I am applying for contains a premium loan feature and I do not pay the policy premiums, the cash value of the policy, if any, will be used to pay the policy premium and these loans will be subject to an interest charge.
- \_\_\_\_\_ I received an explanation of any free look period with instructions on how to cancel if the policy is issued.
- \_\_\_\_\_ I received a complete copy of the proposed Life Policy's Policy Illustration or Policy Summary which illustrates the policy's projected premiums, death benefits and any guaranteed or non-guaranteed values.

I hereby acknowledge:

\_\_\_\_\_  
Signature of U.S. Military Personnel

\_\_\_\_\_  
Date

Statement and Acknowledgement by Sentry Life Insurance Company Agent:

\_\_\_\_\_  
Name of Sentry Life Insurance Company Agent (please print)

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

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

\_\_\_\_\_  
Signature of Sentry Life Company Insurance Agent

\_\_\_\_\_  
Date

340-539

3/08 (✓)



340-539

DOC SCAN

**Business Owned Life Insurance:  
Notice of Intent to Insure and Consent  
by Proposed Insured**



Date: \_\_\_\_\_

Proposed Insured: \_\_\_\_\_

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

\_\_\_\_\_  
Company Name/Employer

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

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

\_\_\_\_\_ Director

\_\_\_\_\_ 5% or Greater Owner of the Company at any time during the preceding year.

\_\_\_\_\_ Received Compensation in Excess of \$115,000 in the preceding year.

\_\_\_\_\_ One of the five highest Paid Officers.

\_\_\_\_\_ Among the Highest Paid 20% of All Employees.

I, \_\_\_\_\_, hereby have been notified that  
Print Name of Proposed Insured

\_\_\_\_\_  
Print Name of Company/Employer

will apply for a Maximum Amount of Life Insurance of \_\_\_\_\_ on my life and I  
Maximum Amount

hereby consent that the Company be the Owner and Beneficiary of any proceeds payable under said Life Insurance Policy on my life during employment or after I terminate my employment or association with said Company/Employer.

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Signature and Title

\_\_\_\_\_  
Date

Employer: Retain in your records. Business owned life insurance may have tax implications. Please consult your tax advisor.

340-1004

9/2013(✓)



340-1004

DOC SCAN

**Business Owned Life Insurance:  
Notice of Intent to Insure and Consent  
by Proposed Insured**



Date: \_\_\_\_\_

Proposed Insured: \_\_\_\_\_

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

\_\_\_\_\_  
Company Name/Employer

\_\_\_\_\_  
Address

\_\_\_\_\_  
City, State, Zip

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

\_\_\_\_\_ Director

\_\_\_\_\_ 5% or Greater Owner of the Company at any time during the preceding year.

\_\_\_\_\_ Received Compensation in Excess of \$115,000 in the preceding year.

\_\_\_\_\_ One of the five highest Paid Officers.

\_\_\_\_\_ Among the Highest Paid 20% of All Employees.

I, \_\_\_\_\_, hereby have been notified that  
Print Name of Proposed Insured

\_\_\_\_\_  
Print Name of Company/Employer

will apply for a Maximum Amount of Life Insurance of \_\_\_\_\_ on my life and I  
Maximum Amount

hereby consent that the Company be the Owner and Beneficiary of any proceeds payable under said Life Insurance Policy on my life during employment or after I terminate my employment or association with said Company/Employer.

\_\_\_\_\_  
Signature of Proposed Insured

\_\_\_\_\_  
Date

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

\_\_\_\_\_  
Print Name and Title

\_\_\_\_\_  
Signature and Title

\_\_\_\_\_  
Date

Employer: Retain in your records. Business owned life insurance may have tax implications. Please consult your tax advisor.

340-1004

9/2013(✓)



340-1004

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