Application For: Advantage Plus®
Limited Benefit Policy Providing Dental and Vision Coverage

Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue Glenview, IL 60025 (800) 338-7452

Advantage Plus / Dental and Vision Coverage

Application for: ☐ New Coverage ☐ Increase of Benefits

If an Increase of Benefits is requested, please list GTL policy/certificate number(s) affected:_____

APPLICANT INFORMATION DELIVER DOCUMENTS TO: ☐ AGENT ☐ INSURED

Applicant 1

1. Last Name _____ 2. First _____ 3. M.I. _____

4. Social Security #_____ 5. Age _____ 6. Date of Birth _____

7. Email Address _____

Applicant 2/Spouse

8. Last Name _____ 9. First _____ 10. M.I. _____

11. Social Security #_____ 12. Age _____ 13. Date of Birth _____

14. Email Address _____

Contact

15. Street Address _____

16. City_____ 17. State_____ 18. Zip Code_____

19. Telephone_____

DENTAL & VISION POLICY	**Applicant 1**	**Applicant 2**
Choose an Annual Benefit Amount:	☐$400 ☐$800 ☐$1200	☐$400 ☐$800 ☐$1200

Total Annual Premium for Dental & Vision Policy:	$	$
Premium Payment Mode: ☐Annual ☐Semi-Annual (.520) ☐Quarterly (.265) ☐Monthly PAC (.084)		
Total Mode Premium for Applicant 1 and Applicant 2	**Applicant 1** $	**Applicant 2** $
Application Fee (if applicable)	$	

Requested Effective Date: ____/____/____
Requested Effective Date cannot be prior to the Application Date. If no Effective Date is requested, the policy will be effective on the date approved by underwriting.

Replacement of Coverage:	Applicant 1	Applicant 2
Will this policy replace any existing insurance with any company? ***If Yes, please list below: The company, type(s) of insurance and policy number(s). Please submit a Replacement Form if required in your state.***	Yes ☐ No ☐	Yes ☐ No ☐

Applicant 1:

Company	Type of Insurance	Policy Number

Applicant 2/Spouse:

Company	Type of Insurance	Policy Number

Acknowledgement & Authorization

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

ALL STATEMENTS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I (WE) UNDERSTAND THAT FRAUDULENT AND MATERIAL OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR RESCISSION, VOIDING, OR REFORMATION OF INSURANCE.

I (We) understand that any changes in my (our) health conditions, from the date of this application until insurance becomes effective, may result in the declination of my (our) coverage. No agent or other representative of GTL has required, permitted, or encouraged me (us) to answer any question inaccurately or has waived any conditions of this application. I (We) have received a copy of the Pre-Notice which describes how information is obtained and used by GTL.

I (We) have received an Outline of Coverage. If this application is completed electronically, I (we) understand the Outline of Coverage will be delivered electronically or with the policy. If the application is completed over the phone the Outline of Coverage will be delivered with the policy.

AUTHORIZATION: I (We) authorize Guarantee Trust Life Insurance Company (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and criminal or motor vehicle records needed to underwrite my (our) application for insurance. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company, pharmacy benefit managers, pharmacies, pharmacy-related facilities which has such information including any medical information provided to any affiliate insurance company on previous applications and medical information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from MIB, Inc. I (We) authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. This Authorization includes all information about drugs, alcoholism, and mental illness. I (We) understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. Although federal regulations require that the Company inform me (us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. I (We) agree that this Authorization will be valid for 24 months from the date signed, and know that I (we) or my (our) authorized representative may have a photocopy of it.

I (We) understand that I (we) have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I (We) understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as GTL has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my (our) agent or to the attention of the Underwriting Manager.

I (We) understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by GTL in accordance with federal or state law. I (We) also understand that my (our) application for insurance can be declined if I (we) choose not to sign this Authorization.

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime. I (We) attest that I (we) have the minimum essential coverage defined in 26 U.S.C. 5000A(f) and required by the Patient Protection & Affordable Care Act.

I (We) agree that I (we) may receive my (our) policy and other GTL correspondence electronically. I (We) acknowledge receipt of the Electronic Delivery and Communications Disclosure, which describes the requirements for Electronic Policy Fulfillment and Communications, as well as my (our) right to opt-out of Electronic Policy Fulfillment and receive a paper copy of my (our) policy (policies), free of charge.

Applicant 1 Signature: _____

Signed at: City and State: _____ Date_____

Applicant 2/Spouse Signature: (if applicable) _____

Signed at: City and State: _____ Date_____

Agent's Statement

I certify that I have accurately recorded the information supplied by the Applicant. I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it. I have advised the applicant not to withhold any information relative to this application and its questions. I have advised the applicant to review the application for completeness and accuracy and that no coverage is in effect until they are notified in writing by Guarantee Trust Life Insurance Company.

_____

Agent's Name (Printed) E-mail Address Agent Code

_____

Agent's Signature Date

APPH6-15-CT

Monthly Pre-Authorized Premium Payment Plan

Authorization to Honor Withdrawals to be drawn by Guarantee Trust Life Insurance Company.

TO: _____

Name of my Bank My Bank's Address City State Zip Code

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of Guarantee Trust Life Insurance Company, Glenview, Illinois provided there are sufficient funds in my account to pay the same upon presentation.

Account #_____ Bank Routing #_____

Account Type: ☐ Checking Account (Attach a Voided "Sample" check)

☐ Savings Account (Attach a Voided "Sample" check if applicable, or a Deposit slip)

I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

_____ _____

Printed name of insured if different from premium payer Premium payer's signature, as it appears on bank records

Requested Draft Date: _____

Receipt

Date_____

Received of _____the sum of $_____ and application for insurance to Guarantee Trust Life Insurance Company. If for any reason the application is declined this payment will be refunded. No liability is created or assumed by the company, except for refund of this payment, until the insurance applied for has been issued.

Agent's Signature:_____

If you do not receive your policy/certificate within 60 days from the date of your application, please write to:
Guarantee Trust Life Insurance Company, 1275 Milwaukee Avenue Glenview, IL 60025
MAKE CHECK PAYABLE TO: GUARANTEE TRUST LIFE INSURANCE COMPANY

GUARANTEE TRUST LIFE INSURANCE COMPANY
Electronic Delivery and Communications Disclosure

Unless otherwise requested by you, all documents that form our insurance relationship will be provided to you in electronic format. These documents include:

- Application(s) and related forms
- Policy or certificate insurance fulfillment documents
- Disclosures, where required by state and / or federal law

In order to access the documents electronically, you will need to:

1. Have access to the internet and be able to view, save and print PDF files (such as Adobe® Reader® 5.0 or higher.)
2. Maintain a valid designated e-mail address. (We reserve the right to validate the e-mail address you provide us.)

You are responsible for accessing, opening and reading communication we send in electronic format. We will consider Electronic Communications to be received by you upon successful delivery to the designated e-mail address you provide. To ensure our Electronic Communications are not blocked in e-mail or spam filters, please add our domain, "gtlic.com", to your safe sender list.

Access to Paper Copies
To ensure you have them when you need them, you should print copies of the documents we send through Electronic Communication. However, you may request from us one paper copy of your policy / certificate fulfillment package free of charge. Except where prohibited by law, we may charge a nominal fee for additional copies requested after the first. You may contact us with your request in writing, by phone, or email as indicated in our Company Contact Information, shown below.

Our Right to Send Paper
We reserve the right to provide paper copies in lieu of Electronic Communication. We would do this in the event of, but not limited to, a system outage, if we suspect fraud, or where the designated email address you have provided to us does not accept emails from us.

Changes to the Terms and Conditions of Electronic Communication
At our discretion, we reserve the right to modify the terms and conditions stated herein. This includes modifying the terms to include additional instances for Electronic Communication other than policy or certificate fulfillment. If we do, we will provide you with notice of such change, its effective date electronically and your choices under the new terms and conditions.

Withdrawal of Consent
You may elect to withdraw your Consent for Electronic Delivery and Communications at any time by contacting us in writing, by phone, or through the Customer Service link on our website. Please see Company Contact Information, below.

Company Contact Information

1. Write us at…
   Guarantee Trust Life Insurance Company
   ATTN: Policyholder Service
   1275 Milwaukee Avenue
   Glenview, IL 60025

2. Call us toll-free at…
   1-800-338-7452

3. Contact us by email by visiting our website…
   Go to www.gtlic.com. Click on the Policyholder tab at the top of the screen. Choose "Customer Service" from the list of options to communicate with us.