GTL | GUARANTEE TRUST LIFE

Application for Limited Home Health Care Indemnity

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

PRODUCER NOTE: Please pre-qualify the Applicant(s) in step 3 prior to completing the application.

Application for: ☐ New Coverage ☐ Increase Benefits

If increase of benefits requested, please list GTL policy/certificate number(s) affected: _____

SEND POLICY TO: ☐ **PRODUCER** ☐ **INSURED**

Applicant 1

Full Legal Name of Applicant _____
First MI Last

Social Security Number_____ /_____ /_____ Age _____ Date of Birth ____ /____ /_____ ☐ Male

Height ft.____in.____ Weight _____lbs. Beneficiary _____ ☐ Female

Applicant 2

Full Legal Name of Applicant _____
First MI Last

Social Security Number ____ /_____ /_____ Age _____ Date of Birth ____ /____ /_____ ☐ Male

Height ft.____in.____ Weight _____lbs. Beneficiary _____ ☐ Female

Address

Home Address _____
Street City State Zip

Applicant 1 E-mail Address _____ Applicant 2 E-mail Address _____

Applicant 1 Phone Number _____ Applicant 2 Phone Number _____

Step 1: Choose Home Health Care Benefit

	Applicant 1	Applicant 2
Premium Payment Mode	☐ Annual ☐ Quarterly ☐ Semi- Annual ☐ Monthly Bank Draft	☐ Annual ☐ Quarterly ☐ Semi-Annual ☐ Monthly Bank Draft
Home Health Care Daily Benefit Option (*Coverage Includes $3,500 Lump Sum Caregiver Rider Benefits.)*	☐ Option A ☐ Option B ☐ Option C Modal Premium $_____	☐ Option A ☐ Option B ☐ Option C Modal Premium $_____

Step 2: Choose Optional Benefits

	Applicant 1			Applicant 2		
Ambulance Rider *(Maximum issue age is 80)*	☐ Modal Premium $_____			☐ Modal Premium $_____		
Accident and Sickness Hospitalization Rider*	Option A:	Option B:	Option C:	Option A:	Option B:	Option C:
Daily Benefit Amount: *(Choose one)*	☐ $100	☐ $100 ☐ $200	☐ $100 ☐ $200 ☐ $300	☐ $100	☐ $100 ☐ $200	☐ $100 ☐ $200 ☐ $300
Benefit Period: *(Choose one)*	☐ 3 Days ☐ 6 Days	☐ 3 Days ☐ 6 Days	☐ 3 Days ☐ 6 Days	☐ 3 Days ☐ 6 Days	☐ 3 Days ☐ 6 Days	☐ 3 Days ☐ 6 Days
**(HIP option must follow base option.)*	Modal Premium $_____			Modal Premium $_____		
Critical Accident Rider	☐ $5,000 ☐ $10,000 Modal Premium $_____			☐ $5,000 ☐ $10,000 Modal Premium $_____		
Return of Premium Rider	☐ At death Modal Premium $_____			☐ At death Modal Premium $_____		

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.

Premiums

Applicant 1 Total Premium: $_____

Applicant 2 Total Premium: $_____

Premiums include an annual $20 Policy Fee

Step 3: Pre-Qualification and Medical Information

If any answer to questions 1-3 is YES (or 1-4 if applying for Option C), do not submit the application.

	Applicant 1	Applicant 2
1. Is the applicant currently (i) living in a nursing home or assisted living facility or (ii) receiving home health care or similar type of care?	☐ Yes ☐ No	☐ Yes ☐ No
2. Does the applicant require the assistance or supervision of another person or a device of any kind for any one of the following routine Activities of Daily Living (bathing, dressing, eating, continence, toileting or transferring to or from a bed or chair)?	☐ Yes ☐ No	☐ Yes ☐ No
3. Within the past 12 months has the applicant been diagnosed as having, been prescribed medication for, or received medical advice or treatment from a licensed healthcare professional for Alzheimer's disease, dementia, or memory loss?	☐ Yes ☐ No	☐ Yes ☐ No
If applying for Option C: 4. In the next 60 calendar days, is the applicant (i) scheduled for or (ii) anticipating the scheduling of: A. Admission to a hospital, nursing home or assisted living facility; or B. Home health care services; or C. Surgery?	☐ Yes ☐ No	☐ Yes ☐ No

Applicant(s) Coverage Information	Applicant 1	Applicant 2
Will any existing supplemental health insurance (including long term care, nursing home, or home health care insurance) be replaced or changed if the proposed coverage is issued? (If "YES," please complete the Replacement Form if required by your state).	☐ Yes ☐ No	☐ Yes ☐ No

If "Yes", for which Company?

Applicant 1_____

Applicant 2_____

ACKNOWLEDGMENTS & 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.

APPLICANT ACKNOWLEDGEMENTS

I hereby apply to Guarantee Trust Life Insurance Company ('GTL') for a policy to be issued in reliance on my answers to the questions in this application for insurance coverage ("Application"). I have read or had read to me the completed Application and I represent that all statements made in this Application and all answers to the medical questions contained in the Application are full, complete and true, to the best of my knowledge and belief. I understand that innocent, negligent or fraudulent (i) omissions, (ii) misrepresentations or (iii) misstatements could result in a reduction of benefits or denial of an otherwise valid claim, or rescission of the insurance coverage. I understand that any changes in my health conditions, from the date of this Application until insurance becomes effective, may result in the declination of my coverage. No producer or other representative of GTL has required, permitted, or encouraged me to answer any question inaccurately or waived any conditions of this Application. I acknowledge I have received or will receive the following in conjunction with my Application: (1) the Outline of Coverage, (2) Notice of Privacy Practices, (3) the Pre-Notice which describes how information is obtained and used by GTL, and (4) A Guide to Health Insurance for People with Medicare and the Medicare Duplication of Benefits Disclosure, if eligible for Medicare.

Applicant Authorization to Obtain and Disclose Medical Information for Underwriting and Claim Purposes ("Authorization")

I hereby authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medical-related facility, pharmacy, pharmacy benefit management company or prescription data base service, insurance carrier, consumer reporting agency, or insurance support organization that has records or knowledge of my past or present health, prescription drug or medication history, other insurance coverage, and criminal or motor vehicle records to give to GTL, and representatives performing services for GTL including its employees, third-party administrators, insurance support organizations, or its reinsurer(s), any such information. This excludes psychotherapy notes. Such information about me may be disclosed to GTL and to any representatives performing services for GTL related to this Application and any policy subsequently issued related thereto ("Policy"). I agree to notify GTL of any change in my health, prescription drug or medications while my Application is in the underwriting process.

I agree this Authorization may also be used to obtain health, prescription drug and/or medication information or records, as stated above, in order to process a claim that is submitted within the timeframe this Authorization remains valid.

I have the right to revoke this Authorization at any time by sending a written request to GTL at 1275 Milwaukee Avenue, Glenview, IL 60025. Attention: Policy Owner Services. I understand revocation of my Authorization will not be effective to the extent GTL has relied on the use or disclosure of my health, prescription drug and/or medication information or so long as GTL has a legal right to contest a claim under the Policy. I understand my Application for insurance can be declined if I choose not to sign this Authorization.

I further understand any protected health information disclosed pursuant to this Authorization, will be protected by GTL in accordance with federal and/or applicable state privacy laws, including but not limited to the Health Insurance Portability and Accountability Act of 1996, as amended.

Electronic Transactions, Electronic Signatures, Policy Fulfillment and Communications

This Application may be completed by electronic device or telephonic means. I acknowledge GTL or the producer has verified my identity in accordance with any applicable federal or state law and that if this Application is completed by electronic means, I have provided my consent and authorization to complete an electronic transaction to apply for this coverage. My electronic signature is legally binding, and has the same effect as if I had physically signed this Application. If this Application is completed by telephonic means, I authorize GTL or its producer to accept my voice signature response as having the same effect as if I had physically signed this Application. I agree that I may receive my Policy and other GTL communications electronically. I also acknowledge receipt of the Electronic Delivery and Communications Disclosure, which describes the requirements for Electronic Policy Fulfillment and Communications, as well as my right to opt-out of Electronic Policy Fulfillment and Communications and receive a paper copy of my Policy free of charge.

Fraud Notice: Any person who knowingly and with intent to defraud or solicit another to defraud an insurer: (1) by submitting an application or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

Applicant 1 Signature: _____

Signed at: City and State: _____ Date: _____

Applicant 2/Spouse (Domestic Partner) Signature: (if applicable) _____

Signed at: City and State: _____ Date: _____

PRODUCER'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.

_____

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

_____

Producer's Signature Date

_____

Secondary Producer Name (Printed) Producer Code Secondary Producer Signature, if applicable

APPH2-21-OR (R823)

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.

Bank Routing #: _____ Account #: _____

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

Requested Draft Date: _____/_____/_____

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 further 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

OREGON INDIVIDUAL HEALTH INSURANCE POLICY
DISCLOSURE STATEMENT

_____
(Agent or insurance company representative)

_____
(Address)

Completed this questionnaire on _____ for
(Date)

_____
(Applicant)

_____
(Address)

describing _____,
(Policy name, form number)

an individual health insurance policy providing coverage for _____

This policy is underwritten by
Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, IL 60025

NOTICE

This disclosure statement answers questions consumers often ask about health insurance coverage and costs. It highlights some of the important issues that frequently affect consumers. It is intended for your use whether you are purchasing health insurance for the first time or whether you are replacing or adding to your existing coverage or whether you are replacing or adding to your existing coverage.

Are *You Considering Replacing Your Current Coverage?* Before you replace your current policy with another, you should review both policies in order to determine whether replacement is in your best interests. The new coverage may be different in important respects. You should be aware of these differences, whether they are temporary or permanent. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy.

Are You Considering Adding to Your Current Coverage? Before you add new coverage to your current coverage, you should review both policies to ensure that you are not purchasing unnecessary coverage. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy and the need for additional coverage.

Questions? Ask for Help. If you have any questions that are not answered by this disclosure statement, be sure to ask your agent or insurer representative.

Read Your Policy! If you purchase the offered policy, read it carefully as soon as you receive it. Because it is an individual policy, you will have an opportunity to send it back and obtain a premium refund.

Fill Out Your Application Carefully! Be sure to fill out all portions of your application completely and truthfully. If misstatements are made or information about your health are omitted from the application, the insurer may void the policy or deny your claims, if your age is misstated, the amounts payable on claims may be reduced.

We hope this disclosure statement will help you with your insurance purchase, However, please note that the statement is not intended to be a part of the policy and that only the language of the policy issued by the insurer is final and binding,

QUESTIONS AND ANSWERS
GENERALLY

1. Does the insurer have a list or doctors or hospitals, or both, under contract that are considered "preferred" or "participating"?
Yes ☐ (Proceed to next question) NO ☐ (Proceed to question 5)

2. May I use doctors or hospitals that are *not* on the list?
Yes ☐ (Proceed to next question) NO ☐ (Proceed to question 5)

3. Will I save money by using the doctors or hospitals on the list instead of others?
YES ☐ NO ☐

4. Will doctors and hospitals on the list accept benefits paid under the policy as full payment and not bill me for the balance (other than for deductibles and co-payments)?
YES ☐ NO ☐

5. (If the coverage offered is comprehensive major medical) Pregnancy Benefits:
(a) What are the policy's benefits and limitations with respect to pregnancy? (Include such applicable limitations as waiting periods and pre-existing conditions periods)

_____

_____

(b) Will the offered policy cover a pregnancy without complications if the pregnancy is in existence at the time of the policy's issuance?
YES ☐ NO ☐

Are You Replacing Coverage?
6. If I replace my current policy with another and there is no lapse or gap in coverage, will my enrollment under the old policy count toward meeting any waiting periods under the new policy, such as for pre-existing condition limitations?
YES ☐ NO ☐

☐ OTHER (Explain) _____

_____

_____

7. Will expenses I incurred under my current policy during the current policy year be credited to the new policy's deductibles?

YES ☐ NO ☐

8. If I have a health condition existing when the offered policy is issued, will that condition be covered as of the date of issuance?

YES ☐ NO ☐ If not, when will it be covered?

_____

_____

9. Does the policy contain any dollar limitations on specific benefits?

YES ☐ NO ☐

Any limits on specific benefits, such as hospitalization?

YES ☐ NO ☐

If "YES" to either question, please explain:

_____

_____

C. Are You Adding Coverage to Your Current Policy?

10. If coverage under the new policy duplicates coverage under my current policy, will the new policy pay if my current policy also pays?

YES ☐ NO ☐

(NOTE: You should ask the agent or company representative who sold you your current policy whether your current policy will pay if the new policy pays.)

Applicant Acknowledgement: _____