GTL | GUARANTEE TRUST LIFE

IMPORTANT: This is a fixed indemnity policy,
NOT health insurance

This fixed indemnity policy may pay you a limited dollar amount if you're sick or hospitalized. You're still responsible for paying the cost of your care.

- The payment you get isn't based on the size of your medical bill.
- There might be a limit on how much this policy will pay each year.
- This policy isn't a substitute for comprehensive health insurance.
- Since this policy isn't health insurance, it doesn't have to include most Federal consumer protections that apply to health insurance.

Looking for comprehensive health insurance?

- **Visit HealthCare.gov** or call **1-800-318-2596** (TTY: 1-855-889-4325) to find health coverage options.
- To find out if you can get health insurance through your job, or a family member's job, contact the employer.

Questions about this policy?

- For questions or complaints about this policy, contact your State Department of Insurance. Find their number on the National Association of Insurance Commissioners' website (naic.org) under "Insurance Departments."
- If you have this policy through your job, or a family member's job, contact the employer.

Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue, Glenview, IL 60025 • Tel: 847.699.0600

Application For Advantage Plus®

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

Advantage Plus

Application for: ☐ New Coverage ☐ Reinstatement ☐ Increase of Benefits

If Reinstatement or Increase requested, please list GTL policy/certificate number(s) affected:_____

APPLICANT INFORMATION

MAIL POLICY TO: ☐ AGENT ☐ INSURED

Applicant 1 (Oldest Person In Household)

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

4. Social Security #_____ 5. ☐ Male ☐ Female 6. Age _____ 7. Date of Birth_____

Applicant 2

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

11. Social Security #_____ 12. ☐ Male ☐ Female 13. Age _____ 14. Date of Birth_____

Contact

15. Street Address _____

16. City_____ 17. State_____ 18. Zip Code_____

19. Telephone_____ 20. E-mail Address _____

Beneficiary (*For Lump Sum Cancer Rider Only*)

Primary Beneficiary_____ Relationship_____

Contingent Beneficiary_____ Relationship_____

Pre-Qualification, Medical Information & Exclusions

ADVANTAGE PLUS

IF YOU ARE BETWEEN THE AGES OF 64 1/2 and 65 1/2, AS OF THE DATE OF THIS APPLICATION, SKIP QUESTIONS 1 THROUGH 5 FOR ADVANTAGE PLUS COVERAGE. *(NOTE: Pre Existing Condition limitations apply without regard to answering questions 1 through 5. If any answer to questions 1 through 5 is **Yes** you are not eligible for coverage.)*	**Applicant 1**	**Applicant 2**
1. In the past 12 months have you been confined as an inpatient to a hospital, nursing home or received home health care?	☐Yes ☐No	☐Yes ☐No
2. In the past 12 months have you had a heart attack, congestive heart failure, stroke, Transient Ischemic Attack (TIA), heart surgery/bypass, malignant melanoma or cancer (other than skin cancer)?	☐Yes ☐No	☐Yes ☐No
3. In the past 12 months have you had, been diagnosed with or been treated for Chronic Obstructive Pulmonary/Lung Disease (COPD/COLD), emphysema, chronic bronchitis, insulin dependent diabetes, dementia, Alzheimer's disease, or chronic liver or chronic kidney disease?	☐Yes ☐No	☐Yes ☐No
4. In the past 12 months have you been advised to have surgery which will require an inpatient stay but have not yet done so?	☐Yes ☐No	☐Yes ☐No
5. In the past 10 years have you ever been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection?	☐Yes ☐No	☐Yes ☐No

LUMP SUM CANCER **(To be completed if choosing this rider)**

1. In the past 5 years has any person to be insured had, been diagnosed as having, received medication for or been treated by a medical professional for:	**Applicant 1**	**Applicant 2**
1a. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions (ARC)? ***If Yes the applicant does not qualify for the plan.***	☐Yes ☐No	☐Yes ☐No
1b. Chronic Obstructive Pulmonary/Lung Disease (COPD/COLD), emphysema or chronic bronchitis requiring the use of two or more medications? ***If Yes the applicant does not qualify for the plan.***	☐Yes ☐No	☐Yes ☐No
1c. Leukemia, Hodgkin's Disease, lymphoma, malignant melanoma, sarcoma, or any internal cancer, or had radiation or chemotherapy for any of these conditions or a pre-leukemic condition, a pre-malignant condition or a condition with malignant potential? ***If Yes the applicant does not qualify for the plan.***	☐Yes ☐No	☐Yes ☐No
2. For any of the conditions which benefits are being applied for, within the past 24 months, has any person to be insured had: • Any abnormal diagnostic test results, awaiting test results, or been advised to have any diagnostic test, or had a medical condition, symptom or abnormality that would have caused a person to seek medical treatment or advice for but not have done so? ***If Yes the applicant does not qualify for the plan.***	☐Yes ☐No	☐Yes ☐No

ADVANTAGE PLUS COVERAGE SELECTION & PREMIUMS

Daily Hospital Confinement Benefit:	**Applicant 1**	**Applicant 2**
Choose an Amount From $100 - $600 (in $10 increments)	$_____ Per Day	$_____ Per Day
Choose Number of Days Payable Per Benefit Period	☐10 Days ☐21 Days	☐10 Days ☐21 Days
Optional Riders:		
1. Skilled Nursing Facility Benefit	☐$100 ☐$150 ☐$200	☐$100 ☐$150 ☐$200
2. Ambulance Service Benefit: (Maximum Issue Age is 80)	☐	☐
3. Lump Sum Hospital Benefit	☐$250 ☐$750 ☐$500	☐$250 ☐$750 ☐$500
4. Surgical Benefit	☐$250 ☐$500 ☐$750 ☐$1,000	☐$250 ☐$500 ☐$750 ☐$1,000
5. Lump Sum Cancer Benefit	☐$2,500 ☐$5,000 ☐$7,500 ☐$10,000	☐$2,500 ☐$5,000 ☐$7,500 ☐$10,000

Total Annual Premium Advantage Plus:	$	$
Premium Payment Mode: ☐Annual ☐Semi-Annual (.520) ☐Quarterly (.265) ☐Monthly PAC (.084)		
	Applicant 1	**Applicant 2**
Total Mode Premiums for Applicant 1 and Applicant 2	$	$
Application Fee (if applicable)	$	$
Total Initial Premium Submitted:	$	

Requested Effective Date: ____/____/____
Requested Effective Date cannot be prior to the Application Date. If no Effective Date is requested, the Effective Date will be the date of the underwriting decision to approve issued coverage.

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:

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 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 or that of my (our) dependents (if applying for dependent coverage), 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.

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 any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. 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 or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any 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 have received an Outline of Coverage. If this application is completed electronically, I 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.

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.

I (We) understand that the coverage applied for is not intended to be a small group health plan. I (We) further understand that this plan is intended to supplement existing hospital, medical expense, major medical or comprehensive health coverage and is not a substitute for such coverage. I am applying as an individual and will be individually underwritten.

Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent act, 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.

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

APPH8-14-ID

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 #_____

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

Bank Routing #_____

☐ 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:_____

Detach Here

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

Consent for Use of Electronic Records and Electronic Signatures

PLEASE PRINT AND SAVE A COPY OF THIS DOCUMENT FOR YOUR RECORDS

In connection with your application for, or administration of, insurance underwritten by Guarantee Trust Life Insurance Company ("GTL"), you are consenting to the use of Electronic Signatures and Electronic Records. GTL is required by law to provide you with certain information relative to (i) electronic delivery of disclosures, notices and other electronic communications (collectively, "Electronic Records") and (ii) Electronic Signature.

Types of Electronic Records Covered by This Consent

Unless you request otherwise, documents that form our insurance relationship will be provided to you electronically.* Electronic Records may include, but are not limited to:

- Application(s) and related forms
- Policy or certificate insurance fulfillment documents
- Disclosures and notices, where required by state and / or federal law
- Customer service forms and claim forms
- Responses to customer service or claim-related communications initiated by GTL or you

Your consent does not apply to policy lapse or termination notices.

* Not all items listed above may be immediately available as an Electronic Record and available for viewing in our Customer Portal. As additional Electronic Records become available, the Customer Portal will alert you to the new viewing options and allow you the opportunity to update your Customer Communication settings.

What You Need in Order to Receive or View Electronic Records

In order to access and view communications and documents GTL makes available to you electronically, you must:

- Have access to the internet and be able to view, save and print Portable Document Files (PDF) using software such as Adobe Acrobat Reader. Adobe Acrobat Reader can be downloaded for free at http://get.adobe.com/reader/
- Maintain a valid active email address. It is your responsibility to provide GTL with your complete and accurate email address, as well as provide prompt notification of any change to it. To ensure Electronic Records are not blocked in email or spam filters, please add GTL's domain, gtlic.com, to your safe sender list.

Your Right to Request Paper Copies

To ensure you have them when you need them, it's recommend that you print copies of the Electronic Records GTL makes available to you, or save them to your personal computer or other electronic device. However, you may request a paper copy of any Electronic Record listed above free of charge. Except where prohibited by law, GTL may charge a nominal fee for additional copies requested after the first. Your request can be sent in writing, by phone, or email as indicated in the Company Contact Information, shown below.

Right to Send Paper
GTL reserves the right to provide paper copies in lieu of Electronic Records. This would be done in the event of, but not limited to, a system outage, if fraud is suspected, or where the designated email address you have provided does not accept emails from GTL.

Changes to the Terms and Conditions of Electronic Communication
GTL reserves the right to modify the terms and conditions stated herein. GTL will provide you with notice electronically of such change, its effective date, and your choices under the new terms and conditions.

Withdrawal of Consent
You may elect to withdraw your consent for Electronic Records at any time by contacting us in writing, by phone, or through the Policyholder - Customer Service link on GTL's website. Please see the 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 *Customer Service* tab at the top of the screen and choose *Customer Support*. In the Customer Support site there is a *Contact Us* option you may use to email us your request.

STATEMENT OF CONSENT

☐ **I AGREE**
By clicking "I agree" and / or providing GTL with your email address, you are consenting to the use of Electronic Records and Electronic Signatures. You acknowledge that you: (1) understand the terms and conditions of receiving insurance documents, disclosures and other communications electronically; (2) have the necessary hardware and software that allow you to receive and view Electronic Records; (3) have a valid active email account; and (4) are responsible for accessing, opening, and reading communication GTL sends or makes available to you in electronic format. GTL will consider electronic communication to be received by you upon successful delivery to the designated email address you provide. You also acknowledge that your Electronic Signature is legally binding and enforceable and is the legal equivalent of your handwritten signature.