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®
A Limited Benefit Policy Providing Hospital Confinement Indemnity Benefits

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

ADVANTAGE PLUS

Application for: ☐ New Coverage ☐ Increase of Benefits

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

SEND POLICY DOCUMENTS TO: ☐ **AGENT** ☐ **INSURED**

Applicant 1

Last Name _____ First Name_____ M.I. ____

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

Applicant 2

Last Name _____ First Name_____ M.I. ____

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

Address

Street Address _____

City _____ State: _____ Zip Code: _____

_____ Applicant 1 E-mail Address

_____ Applicant 2 E-mail Address

Applicant 1 Phone Number _____ Applicant 2 Phone Number _____

Pre-Qualification, Medical Information & Exclusions

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

If any answer to questions 1 through 5 is Yes, you are not eligible for coverage.

NOTE: Pre-existing Condition limitations apply without regard to answering questions 1 through 5.

ADVANTAGE PLUS	Applicant 1	Applicant 2
1. In the past 6 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, Atrial Fibrillation, 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, diabetes treated with insulin, 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. 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

Applicant(s) Coverage Information

	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

ADVANTAGE PLUS COVERAGE SELECTION & PREMIUMS

	Applicant 1	Applicant 2
➤ Daily Benefit Amount for the Initial Benefit Period Choose an amount from $100 to $2,500 (in $10 increments) *The Short Duration Hospital Stay Benefit is included for the 1, 3 and 6 day benefit periods only and optional for 10 day benefit period.* Daily Benefit for a 1 day plan is $1,000 to $2,500 Daily Benefit for a 3 day plan is $350 to $750 Daily Benefit for a 6 day plan is $250 to $750 Daily Benefit for a 10 day plan is $100 to $750 Daily Benefit for the Remainder of the 31 Day Maximum Benefit Period is $10	$_____ Benefit Amount Per Day	$_____ Benefit Amount Per Day
➤ Select number of Benefit Period Days	☐ 1 ☐ 3 ☐ 6 ☐ 10	☐ 1 ☐ 3 ☐ 6 ☐ 10

Optional Riders	Applicant 1	Applicant 2
➤ Ambulance Benefit Rider (Maximum Issue Age is 80)	☐ $50 ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300 ☐ $350 ☐ $400 *Benefit Amount per Ambulance Service*	☐ $50 ☐ $100 ☐ $150 ☐ $200 ☐ $250 ☐ $300 ☐ $350 ☐ $400 *Benefit Amount per Ambulance Service*
➤ Short Duration Hospital Stay Benefit Rider (Available for 10 day benefit period.)	☐	☐
➤ Nursing Facility Benefit Rider Benefits payable from Day 1 through 50	☐ $100 ☐ $150 ☐ $200	☐ $100 ☐ $150 ☐ $200
➤ Outpatient Surgical Benefit Rider	☐ $250 ☐ $500 ☐ $750 ☐ $1,000	☐ $250 ☐ $500 ☐ $750 ☐ $1,000
Total Annual Premium Advantage Plus:	$_____	$_____

Premium Payment Method: ☐ Bank Draft (PAC) ☐ Direct Bill (Collect first premium payment for direct bill mode)

Premium Payment Mode: ☐ Annual ☐ Semi-Annual (.520) ☐ Quarterly (.265) ☐ Monthly (.084) (PAC Only)

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.

Requested Bank Draft Date: _____/_____/_____

Premiums

Applicant 1 Total Premium: $_____

Applicant 2 Total Premium: $_____

Application Fee *(if Applicable)* $_____

Total Submitted Premium: $_____

ACKNOWLEDGEMENTS & 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 TO RELEASE MEDICAL INFORMATION: 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, the Veterans Administration, insurance company, pharmacy benefit managers, pharmacy or pharmacy-related facility 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 (our) 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. In the event my (our) application is approved and coverage is issued, I (We) acknowledge this authorization may also be used to obtain information or records, as stated above, as necessary to process a claim that is submitted within the timeframe during which this authorization remains valid.

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.

This application may be completed by electronic or telephonic means. I (We) acknowledge that the Company or its agent has verified my (our) identity for this purpose in accordance with any applicable law or regulation and that if completed by electronic means, I (We) have provided my (our) consent and authorization to complete an electronic transaction to apply for coverage. This authorization shall constitute an electronic signature, which is legally binding, and has the same effect as if I (we) had physically signed this application. If this application is completed by phone, I (we) authorize the Company or its agent to accept my (our) voice signature response.

FRAUD NOTICE: It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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 Signature, if applicable	Secondary Agent's Signature, if applicable
Agent's Name (please print) Agent Code	Agent's Name (please print) Agent Code
Agent's E-mail Address	Agent's E-mail Address

APPH4-18-WA

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

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 Number_____ Banking Routing Number _____

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 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

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