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

AGENT 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: ☐ **AGENT** ☐ **INSURED**

Applicant 1

Full Legal Name of Applicant _____
Last First MI

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

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

Applicant 2

Full Legal Name of Applicant _____
Last First MI

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	☐ 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 $_____		
Dental and Vision Rider	☐ $400 ☐ $800 ☐ $1,200 Modal Premium $_____			☐ $400 ☐ $800 ☐ $1,200 Modal Premium $_____		
Return of Premium Rider	☐ At death (prior to age 86) Modal Premium $_____			☐ At death (prior to age 86) 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 $6 Policy Fee

Step 3: Pre-Qualification and Medical Information

If any answer to questions 1-2 is YES (or 1-3 if applying for Option C), do not submit the application.

	Applicant 1	Applicant 2
1. Is the applicant currently in a nursing home/assisted living facility or receiving home health care or similar type of benefits?	☐ Yes ☐ No	☐ Yes ☐ No
2. Is the applicant unable to perform routine Activities of Daily Living (bathing, dressing, eating, continence, toileting or transferring to or from a bed or chair without physical assistance) or cognitively impaired?	☐ Yes ☐ No	☐ Yes ☐ No
If applying for Option C: 3. In the next 60 days, does the applicant expect to be admitted to a hospital, nursing home/assisted living facility or require home health care services or have 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 _____

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.

APPLICANT ACKNOWLEDGEMENTS

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, INTENTIONAL 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 Guarantee Trust Life Insurance Company (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 manager, pharmacies or pharmacy-related facility which have 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 this authorization will be valid for 24 months from the date signed. 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.

I (We) agree that I (we) may receive my (our) policy and other GTL correspondence in electronic format. 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.

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.

Applicant 1 Signature: _____

Signed at: City and State: _____ Date: _____

Applicant 2 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

APPH5-16-MS

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

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 the below Notice to Applicant and Receipt and leave with applicant*----------

NOTICE TO APPLICANT – PARTS 1 AND 2

Part 1: Fair Credit Reporting Act and Privacy Act Pre-Notification

The application you completed for insurance with us, in most cases, gives us all the information we need. In certain cases, we may need more information.

If we need more information, we may get it by talking to other persons you know including, but not limited to, your agent or other insurance companies you have applied to. We may ask an independent "consumer reporting agency" to help us verify facts or get additional facts.

We may collect information concerning your health, job and financial situation, as well as your character, general reputation and mode of living. We will not collect information relating to your sexual orientation.

The personal information we obtain about you is treated as confidential and will not be discussed to other persons or organizations without your written authorization except to the extent necessary as permitted by law, for the conduct of our business. But any information collected by a "consumer reporting agency" may be shared by the agency with others who use such information, but only to the extent which the Fair Credit Reporting Act Permits. You have a right of access, and right of correction, concerning recorded personal information obtained in our file. In order to exercise these rights, you must contact us in writing requesting access or correction.

You have no access right to privileged information. If we used a "consumer reporting agency," you have the right to: (1) ask to talk with them and (2) ask them about their report. You may write us for the name and address of the agency. This paragraph is not intended as a complete description of your right of access and correction. If you would like a more complete description of our insurance information and Privacy Protection Practices, please write: Guarantee Trust Life Insurance Company, 1275 Milwaukee Avenue Glenview, IL 60025.

Part 2: Notification Regarding MIB, Inc.

Information regarding your insurability will be treated as confidential. Guarantee Trust Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc., will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address to the MIB, Inc. information office is 50 Braintree Hill Park, Suite 400, Braintree Massachusetts 02184-8734, telephone number (866) 692-6901, e-mail address infoline@mib.com. Guarantee Trust Life Insurance Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

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