

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

If applying for the Lump Sum Cancer Rider or Critical Accident Rider, please provide Beneficiary information below:

Full Legal Name of Beneficiary

Applicant 2

Last Name _____ First Name _____ M.I. _____

Social Security Number _____ / _____ / _____ Age _____ Date of Birth _____ / _____ / _____ Male Female

If applying for the Lump Sum Cancer Rider or Critical Accident Rider, please provide Beneficiary information below:

Full Legal Name of Beneficiary

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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> 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?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

LUMP SUM CANCER (To be completed if applying for Lump Sum Cancer Rider)	Applicant 1	Applicant 2
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: <ul style="list-style-type: none"> a. Chronic Obstructive Pulmonary/Lung Disease (COPD/COLD), emphysema or chronic bronchitis requiring the use of two or more medications? <i>If Yes, the applicant does not qualify for the rider.</i> b. 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? <i>If Yes, the applicant does not qualify for the rider.</i> 	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Yes <input type="checkbox"/> No
2. In the past 5 years, has any person to be insured had, been diagnosed as having, received medication for, or been treated by a physician or an appropriately licensed clinical professional acting within the scope of his/her license for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)? <i>If Yes, the applicant does not qualify for the rider.</i>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. For any of the conditions which benefits are being applied for, within the past 24 months, has any person to be insured had: <ul style="list-style-type: none"> a. An abnormal test result or a medical condition which requires further diagnostic evaluation or testing but has not yet been completed; or had a symptom or abnormality that would have caused a person to seek medical attention or advice for but has not yet done so; or is awaiting test results? <i>If Yes, the applicant does not qualify for the rider.</i> 	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

ADVANTAGE PLUS COVERAGE SELECTION & PREMIUMS

- ▶ Daily Hospital Confinement
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 and 21 day benefit periods.

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 or 21 day plan is \$100 to \$750

- ▶ Select number of Benefit Period Days

Applicant 1	Applicant 2
\$ _____ Benefit Amount Per Day	\$ _____ Benefit Amount Per Day
<input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 10 <input type="checkbox"/> 21	<input type="checkbox"/> 1 <input type="checkbox"/> 3 <input type="checkbox"/> 6 <input type="checkbox"/> 10 <input type="checkbox"/> 21

Optional Riders	Applicant 1	Applicant 2
▶ Ambulance Service Benefit Rider (Maximum Issue Age is 80)	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200 <input type="checkbox"/> \$250 <input type="checkbox"/> \$300 <input type="checkbox"/> \$350 <input type="checkbox"/> \$400 <i>Benefit Amount per Ambulance Service</i>	<input type="checkbox"/> \$50 <input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200 <input type="checkbox"/> \$250 <input type="checkbox"/> \$300 <input type="checkbox"/> \$350 <input type="checkbox"/> \$400 <i>Benefit Amount per Ambulance Service</i>
▶ Short Duration Hospital Stay Benefit Rider (Available for 10 and 21 day benefit period.)	<input type="checkbox"/>	<input type="checkbox"/>
▶ Skilled Nursing Facility Benefit Rider (choose one) Option 1: Benefits payable from Day 1 through 50 OR Option 2: Benefits payable from Day 21 through 100	<input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200 OR <input type="checkbox"/> \$120	<input type="checkbox"/> \$100 <input type="checkbox"/> \$150 <input type="checkbox"/> \$200 OR <input type="checkbox"/> \$120
▶ Lump Sum Cancer Benefit Rider (Includes \$500 Basal Cell/Squamous Cell Skin Carcinoma benefit and 25% Cancer In-Situ Benefit)	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$6,700 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> With 100% Recurrence Benefit	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$6,700 <input type="checkbox"/> \$10,000 <input type="checkbox"/> \$15,000 <input type="checkbox"/> \$20,000 <input type="checkbox"/> With 100% Recurrence Benefit
▶ Critical Accident Benefit Rider	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000
▶ Outpatient Surgical Benefit Rider	<input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000	<input type="checkbox"/> \$250 <input type="checkbox"/> \$500 <input type="checkbox"/> \$750 <input type="checkbox"/> \$1,000
▶ Dental and Vision Benefit Rider	<input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200	<input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200
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: \$ _____

Applicant(s) Coverage Information

Applicant 1	Applicant 2
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

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.**

Applicant 1:

Company _____ Type of Insurance _____ Policy Number _____

Applicant 2:

Company _____ Type of Insurance _____ Policy Number _____

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 manager, 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: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly presents false information in an application for insurance is guilty of a crime and may be subject to restitution fines or confinement in prison, or any combination thereof.

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-AL

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

Receipt

 - Detach Here

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

**IMPORTANT NOTICE ABOUT THE POLICY/CERTIFICATE OF INSURANCE FOR WHICH YOU
HAVE APPLIED**

**THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS
READ THE FOLLOWING INFORMATION CAREFULLY**

- 1. THE POLICY/CERTIFICATE FOR WHICH YOU HAVE APPLIED INCLUDES A BINDING ARBITRATION AGREEMENT.**
- 2. THE ARBITRATION AGREEMENT REQUIRES THAT ANY DISAGREEMENT RELATED TO THIS POLICY/CERTIFICATE MUST BE RESOLVED BY ARBITRATION AND NOT IN A COURT OF LAW.**
- 3. THE RESULTS OF THE ARBITRATION ARE FINAL AND BINDING ON YOU AND THE INSURANCE COMPANY.**
- 4. IN AN ARBITRATION, AN ARBITRATOR, WHO IS AN INDEPENDENT, NEUTRAL PARTY, GIVES A DECISION AFTER HEARING THE POSITIONS OF THE PARTIES.**
- 5. WHEN YOU ACCEPT THIS INSURANCE POLICY/CERTIFICATE YOU AGREE TO RESOLVE ANY DISAGREEMENT RELATED TO THE POLICY/CERTIFICATE BY BINDING ARBITRATION INSTEAD OF A TRIAL IN COURT INCLUDING A TRIAL BY JURY.**
- 6. ARBITRATION TAKES THE PLACE OF RESOLVING DISPUTES BY A JUDGE AND JURY AND THE DECISION OF THE ARBITRATOR CANNOT BE REVIEWED IN COURT BY A JUDGE AND JURY.**

ACKNOWLEDGEMENT OF ARBITRATION AGREEMENT

I HAVE READ THIS STATEMENT. I UNDERSTAND THAT I AM VOLUNTARILY SURRENDERING MY RIGHT TO HAVE ANY DISAGREEMENT BETWEEN THE INSURANCE COMPANY AND MYSELF RESOLVED IN COURT. THIS MEANS I AM WAIVING MY RIGHT TO A TRIAL BY JURY.

I UNDERSTAND THAT UPON RECEIPT OF THE POLICY/CERTIFICATE I SHOULD READ THE ARBITRATION CLAUSE CONTAINED IN THE POLICY/CERTIFICATE AND THAT I HAVE THE RIGHT TO REJECT THIS POLICY/CERTIFICATE WITHIN THREE (3) DAYS OF THE DATE OF DELIVERY IF I DO NOT WANT TO ACCEPT THE REQUIREMENT FOR ARBITRATION.

I UNDERSTAND THAT THIS SAME TYPE OF INSURANCE MAY BE AVAILABLE THROUGH AN INSURANCE COMPANY THAT DOES NOT REQUIRE THAT POLICY/CERTIFICATE RELATED DISAGREEMENTS BE RESOLVED BY BINDING ARBITRATION.

SIGNATURE OF PROPOSED INSURED

DATE

TIME

**SIGNATURE OF APPLICANT/OWNER
(IF OTHER THAN PROPOSED INSURED)**

DATE

TIME

SIGNATURE OF AGENT

DATE

TIME

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