GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 MILWAUKEE AVENUE • GLENVIEW • ILLINOIS 60025 • 1-800-338-7452

APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

APPLICANT Last Name _____ First Name _____ M.I. _____

Soc. Security # _____ Age _____ Date of Birth _____/_____/_____ Sex ____

What is your Medicare Claim Number? _____

Phone Number _____ E-mail address _____

ADDRESS Number & Street _____ City _____ State _____ Zip _____

SEND DOCUMENTS TO: ☐ AGENT ☐ INSURED

Plan Selection & Payment Information

1. I apply for Medicare Supplement Plan:
   Medicare Eligible Before 1/1/20
   ☐A ☐C ☐F ☐G ☐N
   Medicare Eligible 1/1/20 and After
   ☐A ☐G ☐N
2. Rate Class:* ☐ Preferred ☐ Standard
   **Agent: Please refer to the Underwriting Guide for eligibility/Rate Class selection*
3. Does any other person who is age 18 or older currently reside in your household? ☐ Yes ☐ No
   If "Yes", applicant is eligible for a household discount to be applied to the premium rate
4. Requested Effective Date or Replacement Date: _____
5. Premium Mode:
   ☐ Annual ☐ Semi Annual
   ☐ Quarterly ☐ Monthly Bank Draft

Requested Draft Date:
_____

Total Modal Premium: $ _____

Premium Paid with Application: $_____

PAYOR INFORMATION (TO BE COMPLETED ONLY IF PAYOR IS OTHER THAN THE INSURED)

Name _____ Relationship _____

Street Address _____ City _____ State _____ Zip _____

MEDICARE COVERAGE QUESTIONS

Questions 6 through 10 must be answered.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application.

PLEASE ANSWER ALL OF THE QUESTIONS COMPLETELY.
Please mark Yes or No with an "X". To the best of your knowledge:

6. Are you covered for medical assistance through the state Medicaid program?……..... **NOTE TO APPLICANT:** If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question.	☐ Yes ☐ No
If you answer yes a. Will Medicaid pay your premiums for this Medicare Supplement policy? …….....	☐ Yes ☐ No
b. Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?….....	☐ Yes ☐ No
7. a. Did you turn age 65 in the last 6 months? …….....	☐ Yes ☐ No
b. Did you enroll in Medicare Part B in the last 6 months or will you enroll in Medicare Part B in the next 6 months?	☐ Yes ☐ No
If yes, what is/was the effective date? _____	
c. Are you eligible for Medicare due to a reason other than age?.....	☐ Yes ☐ No
If yes, what is the date you became eligible for Medicare? _____	
8. a. Do you have another Medicare Supplement policy in force?.....	☐ Yes ☐ No
b. If so, with what company and what plan do you have? _____	
c. If so, do you intend to replace your current Medicare Supplement policy with this policy?.....	☐ Yes ☐ No

9. a. If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates below. If you are still covered under this plan, leave "END" blank. START _____/_____/_____ END _____/_____/_____	
b. If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? ……..……....	☐ Yes ☐ No
c. Was this your first time in this type of a Medicare plan? ……..……..……..…...	☐ Yes ☐ No
d. Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ……..…….....	☐ Yes ☐ No
10. Have you had coverage under any other health insurance within the past 63 days?…… (For example, Railroad Retirees, teachers plans, an employer union, group major medical or individual plan) a. If so, with what company, what kind of policy and amount of coverage if known? _____ _____ _____	☐ Yes ☐ No
b. What are your dates of coverage under the other policy? START _____/_____/_____ END _____/_____/_____ *(If you are still covered under the other policy, leave the "END" blank.)*	

HEALTH QUESTIONS Questions 11 through 21 must be answered.

If you enrolled in Medicare Part B within the past 6 months, or are in an open enrollment or in a Guaranteed Issue Period, you do not have to answer the following questions. Otherwise, you must answer the following questions. Please note, if you answer "Yes" to any question 11 through 18, you are not eligible for coverage.

11. Have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? ……..…...	☐ Yes ☐ No
12. Have you been advised by a physician that surgery may be required within the next 12 months for cataract(s)?..	☐ Yes ☐ No
13. Have you been hospitalized two or more times within the last two years? …….....	☐ Yes ☐ No
14. Are you currently hospitalized, bedridden, living in a nursing facility, using a wheelchair or a motorized mobility aid?...…….....	☐ Yes ☐ No
15. Have you had an organ transplant? …….....	☐ Yes ☐ No
16. Have you been diagnosed with emphysema, chronic pulmonary disorder other than asthma, Parkinson's disease, systemic lupus, myasthenia gravis, multiple sclerosis, ALS (amyotrophic lateral sclerosis), osteoporosis with a fracture or fractures, cirrhosis, Alzheimer's disease, senile dementia or any other cognitive disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC,) or Human Immunodeficiency Virus (HIV) infection?.....……..……..…….....……..….	☐ Yes ☐ No
17. If you have been diagnosed with diabetes, have you also been diagnosed with retinopathy, diagnosed with neuropathy, diagnosed with heart disease, treated for high blood pressure with three or more medications, or advised by a medical professional to take more than 50 units of insulin daily or more than two medications (insulin or oral)? .. …….. …….. ……	☐ Yes ☐ No
18. Within the past two years, have you been treated or been advised by a physician to have treatment for internal cancer, melanoma, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric hospitalization, chronic hepatitis, chronic kidney disease, coronary artery disease, carotid artery disease, heart rhythm disorders including use of pacemaker or defibrillator, heart attack, congestive heart failure, enlarged heart, stroke, Transient Ischemic Attack (TIA,) heart valve surgery, peripheral vascular disease, rheumatoid arthritis, crippling or disabling arthritis, or amputation caused by disease?	☐ Yes ☐ No
19. Have you used any tobacco product in the last 12 months?	☐ Yes ☐ No
20. Applicant Height _____ (Ft.) _____ (In.) Weight _____ (Lbs.)	
21. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If, yes list the medication(s) name, frequency and dosage, and diagnosis/condition/reason for the medication.	☐ Yes ☐ No

Please attach a separate sheet if needed	
Medication name (copy from pharmacy label)	
Frequency and dosage	
Diagnosis / Condition / Reason for medication	
Medication name (copy from pharmacy label)	
Frequency and dosage	
Diagnosis / Condition / Reason for medication	
Medication name (copy from pharmacy label)	
Frequency and dosage	
Diagnosis / Condition / Reason for medication	

DISCLOSURE & AUTHORIZATION

DISCLOSURE: You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy, (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days after losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Los-Income Medicare Beneficiary (SLMB).

APPLICANT'S AUTHORIZATION & AGREEMENT: I 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 physical condition, other coverage and any other information needed to underwrite my application for insurance such as criminal or motor vehicle records. Underwriting will only be performed if I am not in an open enrollment or guarantee issue period. 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, pharmacy benefit manager, pharmacy or pharmacy-related facility, insurance company 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 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 agree that this Authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it. Although federal regulations require that the Company inform me 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 understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I 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 the Company has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my agent or to the attention of the Underwriting Manager.

I also understand that my application for insurance can be declined if I choose not to sign this Authorization.

ACKNOWLEDGEMENTS: The Applicant represents and agrees as follows: 1) That the statements contained in the application concerning past and present health are complete. 2) Any coverage issued as a result of this application shall, together with this application, constitute a single and entire contract of insurance. 3) No agent or any other person is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Company's rights or requirements. 4) Any insurance issued as a result of the application will not take effect unless and until the full first premium is paid and the policy is delivered during such person's lifetime. 5) Provisions concerning exceptions, exclusions, limitations and renewal of the insurance plan which has been applied for, have been explained and are understood. 6) The applicant shall be owner of any insurance applied for. 7) The applicant acknowledges receipt of the Outline of Coverage, and has read the authorization and received copies of the "Notice to Applicant, Parts 1 and 2" describing MIB, Inc. and explaining the rights of the applicant under the Fair Credit Reporting Act.

AGREEMENT: I have read, or had read to me, the completed application. I hereby agree that: 1) all the statements and answers in this application are complete and true to the best of my knowledge and belief and are representations and not warranties; and 2) **no insurance will be effective until my policy is issued.**

I agree that I may receive my policy and other GTL correspondence electronically. I 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 receive a paper copy of my policy free of charge.

Caution: If your answers on this application are incorrect or untrue, Guarantee Trust Life Insurance Company may deny benefits or rescind your policy.

Any person who knowingly and with intent to defraud any 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 insurance act, which is a crime.

_____

Applicant's Signature | City & State signed | Date

AGENT'S REPORT: List of health policies or certificates I have sold to the Applicant which are still in force:

NAME OF INSURER	POLICY TYPE

List of health policies or certificates I have sold to the Applicant in the last 5 years that are not in force:

NAME OF INSURER	POLICY TYPE

AGENT'S STATEMENT

I certify: 1) I have accurately recorded the information supplied by the Applicant; 2) I have given the Applicant an Outline of Coverage for the policy being applied for and the Guide to Health Insurance for People with Medicare; and 3) I have reviewed the current health coverage of the Applicant and have completed the chart above, as applicable. I find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.

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**

TYPE OF SALE: ☐ In Person ☐ Telephone ☐ On-line ☐ Mail

APPH4-15(B)-KY

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 #: Bank Routing #:

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

---------- *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 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. As part of your consent to the use of Electronic Signatures and Electronic Records 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.

*An active email address is not required for viewing and / or downloading a copy of your insurance coverage from GTL's secure website.

GTL is required by law to provide you with the following 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 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.

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.