APPLICATION FOR LIMITED BENEFIT POLICY

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue, Glenview, IL 60025 (800) 338-7452

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

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

MAIL POLICY TO: ☐ Agent ☐ Insured

PART A. APPLICANT(S) INFORMATION

APPL #1	Last Name _____ First Name _____ M.I ___ Birth Date_____ Soc. Sec. # _____ Sex _____ Age _____
APPL #2	Last Name _____ First Name _____ M.I ___ Birth Date_____ Soc. Sec. # _____ Sex _____ Age _____
ADDRESS	Street Address _____ City _____ State _____ Zip Code _____ Telephone (Day) _____ E-Mail Address _____

IF YOU ARE 6 MONTHS YOUNGER OR OLDER THAN 65, AS OF THE DATE OF THIS APPLICATION SKIP TO SECTION B.

QUALIFYING INFORMATION (If any answer to questions 1 thru 5 is "YES" you are not eligible for coverage.)

	Applicant #1	Applicant # 2
SECTION A.		
1. In the past 12 months have you been confined as an inpatient to a hospital, nursing home or have you received home health care?	☐YES ☐NO	☐YES ☐ NO
2. In the past 12 months have you had a heart attack, stroke, heart surgery/ bypass, malignant melanoma or cancer (other than skin cancer)?	☐YES ☐NO	☐YES ☐ NO
3. In the past 12 months have you been treated for chronic obstructive lung disease, insulin dependent diabetes, dementias, Alzheimer's disease, congestive heart failure, or chronic liver or kidney disease?	☐YES ☐NO	☐YES ☐ NO
4. In the past 12 months have you had surgery which required an inpatient hospital stay or 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 HIV infection?	☐YES ☐NO	☐YES ☐ NO
SECTION B. (To be completed if choosing the Lump Sum Cancer Rider; if question 6 or 7 is answered "YES" you are not eligible for the Lump Sum Cancer Rider.)		
6. In the past 10 years, have you had, been diagnosed as having, received medication for, or been treated by a medical practitioner for leukemia, Hodgkin's or Non-Hodgkin's disease, malignant melanoma, sarcoma or any other internal cancer or had radiation or chemotherapy for any of these conditions?	☐YES ☐NO	☐YES ☐ NO
7. In the past 24 months, have you been advised to seek treatment or medical advice from a medical practitioner, or had experienced any symptoms that you sought medical advice for any of the medical conditions listed in question #6?	☐YES ☐NO	☐YES ☐ NO
SECTION C.		
8. Will this policy replace any existing insurance with any company? If "YES", what company, type(s) of insurance and policy number(s) _____ _____	☐YES ☐NO	☐YES ☐ NO

PART B. COVERAGE SELECTION *Complete appropriate section for each plan selected*

Daily Hospital Confinement Benefit • Choose an amount from $100 - $600 (in $10 increments) • Choose Number of Days Payable Per Benefit Period	**Applicant #1** $_____ per day ☐ 10 Days ☐ 21 Days	**Applicant #2** $_____ per day ☐ 10 Days ☐ 21 Days
Optional Riders: Lump Sum Hospital Benefit: Choose 1 of 3 Benefit Amounts	☐ $250 ☐ $500 ☐ $750	☐ $250 ☐ $500 ☐ $750
Ambulance Service Benefit (maximum age – 80)	☐	☐
Durable Medical Equipment Benefit	☐	☐
Skilled Nursing Facility Benefit	☐	☐
Accidental Death and Dismemberment (maximum age – 80) • Choose Benefit Level • Choose Beneficiary	☐ $10,000 ☐ $5,000 _____ _____ Beneficiary and Relationship	☐ $10,000 ☐ $5,000 _____ _____ Beneficiary and Relationship
Lump Sum Cancer Rider: Choose 1 of 4 Benefit Amounts	☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000	☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000
Surgical Benefit Rider: Choose 1 of 4 Benefit Amounts	☐ $250 ☐ $500 ☐ $750 ☐ $1000	☐ $250 ☐ $500 ☐ $750 ☐ $1000

PART C. PREMIUMS

	Applicant #1	**Applicant #2**
Daily Hospital Indemnity Annual Premium	$_____	$_____
Optional Rider Annual Premium		
Lump Sum Hospital Benefit:	$_____	$_____
Ambulance Service Benefit:	$_____	$_____
Durable Medical Equipment Benefit:	$_____	$_____
Skilled Nursing Facility Benefit:	$_____	$_____
Accidental Death & Dismemberment Benefit:	$_____	$_____
Lump Sum Cancer:	$_____	$_____
Surgical Benefit:	$_____	$_____
Total Annual Premium:	$_____	$_____

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

	Applicant #1	**Applicant #2**
Total Mode Premium for Applicants #1 and #2	$_____	$_____
Total submitted Premium:	$_____	

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 issuance coverage.

ACKNOWLEDGEMENTS & AUTHORIZATION

ALL STATEMENTS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I UNDERSTAND THAT OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR RESCISSION, VOIDING, OR REFORMATION OF INSURANCE.

I understand that insurance applied for will not become effective until: a) approved and issued by GTL; b) I have been furnished written notice of the effective date; and c) I have paid the premium in full. I understand that any changes in my health conditions, if applicable, from the date of this application until insurance becomes effective, may result in the declination of my coverage. No agent or other representative of GTL has required, permitted, or encouraged me to answer any question inaccurately or has waived any conditions of this application. I have received a copy of the Pre-Notice which describes how information is obtained and used by GTL. If this application is completed electronically, I understand the Pre-Notice will be delivered electronically or with the policy. If the application is completed over the phone the Pre-Notice will be delivered with the policy.

AUTHORIZATION: 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. 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 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. This Authorization includes all information about drugs, alcoholism, and mental illness. I 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. 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.

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 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 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 agent or to the attention of the Underwriting Manager.

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

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Signed at

Date	City and State
Applicant #1 Signature	Applicant #2 Signature (if applicable)

AGENT'S STATEMENT

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 the applicant is notified in writing by Guarantee Trust Life Insurance Company. I certify that I asked all the questions and truthfully and accurately recorded the answers contained herein (except if application is completed electronically or over the phone). To the best of my knowledge and belief, the insurance applied for: □ is or is likely or □ is not or is not likely to replace or change any existing policy(ies) or contract(s).

Agent's Name (Printed) Agent Code

Agent's Signature Date

Agent's E-mail Address

APPH1-07-IN

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 is 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

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