Application For:
Advantage Plus® & Lump Sum Cancer Insurance

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

Advantage Plus

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

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

Lump Sum Cancer

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

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

APPLICANT INFORMATION

MAIL POLICY TO: ☐ AGENT ☐ INSURED

Applicant 1 (Oldest Person In Household)

1. Last Name _____ 2. First _____ 3. M.I. _____

4. Social Security #_____ 5. ☐ Male ☐ Female 6. Age _____ 7. Date of Birth_____

Applicant 2/Spouse (Includes civil union and domestic partners where authorized by state law)

8. Last Name _____ 9. First _____ 10. M.I. _____

11. Social Security #_____ 12. ☐ Male ☐ Female 13. Age _____ 14. Date of Birth_____

Contact

15. Street Address _____

16. City_____ 17. State_____ 18. Zip Code_____

19. Telephone_____ 20. E-mail Address _____

Beneficiary (*For Lump Sum Cancer Only*)

Primary Beneficiary_____ Relationship_____

Contingent Beneficiary_____ Relationship_____

Pre-Qualification, Medical Information & Exclusions

ADVANTAGE PLUS

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. *(NOTE: Pre Existing Condition limitations apply without regard to answering questions 1 through 5. If any answer to questions 1 thru 5 is* ***Yes*** *you are not eligible for coverage.)*	**Applicant 1**	**Applicant 2**
1. In the past 12 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, 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, insulin dependent diabetes, 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 tested positive for or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) or the HIV virus?	☐Yes ☐No	☐Yes ☐No

LUMP SUM CANCER **(To be completed if choosing this product)**

	Applicant 1	**Applicant 2/Spouse**
1. In the past 12 months has any person to be insured used tobacco products or products containing nicotine of any type? ***If Yes tobacco rates will apply.***	☐Yes ☐No	☐Yes ☐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 medical professional for:		
2a. Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS)? **If Yes, the applicant does not qualify for the plan.**	☐Yes ☐No	☐Yes ☐No
2b. Chronic Obstructive Pulmonary/Lung Disease (COPD/COLD), emphysema or chronic bronchitis requiring the use of two or more medications? ***If Yes the applicant does not qualify for the plan.***	☐Yes ☐No	☐Yes ☐No
2c. 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? ***If Yes the applicant does not qualify for the plan.***	☐Yes ☐No	☐Yes ☐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: • Any abnormal diagnostic test results, awaiting test results, or been advised to have any diagnostic test, or had a medical condition, symptom or abnormality that would have caused a person to seek medical treatment or advice for but not have done so? ***If Yes the applicant does not qualify for the plan.***	☐Yes ☐No	☐Yes ☐No

ADVANTAGE PLUS COVERAGE SELECTION & PREMIUMS

Daily Hospital Confinement Benefit:	**Applicant 1**	**Applicant 2**
Choose an Amount From $100 - $600 (in $10 increments)	$_____ Per Day	$_____ Per Day
Choose Number of Days Payable Per Benefit Period	☐10 Days ☐21 Days	☐10 Days ☐21 Days
Optional Riders:		
1. Skilled Nursing Facility Benefit	☐$100 ☐$150 ☐$200	☐$100 ☐$150 ☐$200
2. Ambulance Service Benefit: (Maximum Issue Age is 80)	☐	☐
3. Lump Sum Hospital Benefit	☐$250 ☐$750 ☐$500	☐$250 ☐$750 ☐$500
4. Surgical Benefit	☐$250 ☐$500 ☐$750 ☐$1,000	☐$250 ☐$500 ☐$750 ☐$1,000

Total Annual Premium Advantage Plus:	$	$
Premium Payment Mode: ☐Annual ☐Semi-Annual (.520) ☐Quarterly (.265) ☐Monthly PAC (.084)		
Total Mode Premium for Applicant 1 and Applicant 2	**Applicant 1** $	**Applicant 2** $
Application Fee (if applicable)	$	$

LUMP SUM CANCER COVERAGE SELECTION & PREMIUMS

1. Plan Type: Select One ☐Individual ☐Couple (*If Couple - Only Complete For Applicant 1*)	**Applicant 1** ☐	**Applicant 2/Spouse** ☐
2. Stand Alone Cancer Policy:	☐$5,000 ☐$10,000 ☐$15,000 ☐$20,000	☐$5,000 ☐$10,000 ☐$15,000 ☐$20,000
Premium Payment Mode: ☐Annual ☐Semi-Annual (.520) ☐Quarterly (.265) ☐Monthly PAC (.09)		
3. Total Modal Premium: (Premium Calculated Includes a $20 Annual Policy Fee)	$_____ Total	$_____ Total

Submitted Premium Totals:	**Applicant 1**	**Applicant 2**
Advantage Plus:	$	$
Lump Sum Cancer:	$	$
Totals:	$	$
Total Initial Premium Submitted:	$	

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 issued coverage.

Replacement of Coverage:	Applicant 1	Applicant 2/Spouse
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
Company	Type of Insurance	Policy Number

Applicant 2/Spouse:

Company	Type of Insurance	Policy Number
Company	Type of Insurance	Policy Number

Acknowledgement & Authorization

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 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 or that of my (our) dependents (if applying for dependent coverage), 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.

AUTHORIZATION: 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 any other information needed to underwrite my (our) 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, pharmacy benefit managers, pharmacies, pharmacy-related facilities 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 the Medical Information Bureau. I (We) authorize the Company, or its reinsurers, to make a brief report of my personal health information to the MIB. 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.

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.

I (We) understand that the coverage applied for is not intended to be a small group health plan. I (We) further understand that this plan is intended to supplement existing hospital, medical expense, major medical or comprehensive health coverage and is not a substitute for such coverage. I am applying as an individual and will be individually underwritten.

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

We are required to give you this notice: Any person who, with the intent to defraud or knowledge that he is facilitating a fraud against the insurer, submits an application or files a claim containing false, incomplete, or deceptive statements of material fact may be guilty of insurance fraud.

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 Name (Printed) E-mail Address Agent Code

_____

Agent's Signature Date

APPH7-13-TX

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 #_____

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

Bank Routing #_____

☐ 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 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

Requested Draft Date:_____

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