



## Step 2: Choose Optional Benefits

	Applicant 1			Applicant 2		
Ambulance Rider <i>(Maximum issue age is 80)</i>	<input type="checkbox"/> Modal Premium \$ _____			<input type="checkbox"/> Modal Premium \$ _____		
Accident and Sickness Hospitalization Rider*	Option A:	Option B:	Option C:	Option A:	Option B:	Option C:
Daily Benefit Amount during the Initial Benefit Period:	<input type="checkbox"/> \$100	<input type="checkbox"/> \$100	<input type="checkbox"/> \$100	<input type="checkbox"/> \$100	<input type="checkbox"/> \$100	<input type="checkbox"/> \$100
Daily benefit for the remainder of the 31 day Maximum Benefit Period is \$15 <i>(Choose one)</i>		<input type="checkbox"/> \$200	<input type="checkbox"/> \$200		<input type="checkbox"/> \$200	<input type="checkbox"/> \$200
			<input type="checkbox"/> \$300			<input type="checkbox"/> \$300
Benefit Period: <i>(Choose one)</i>	<input type="checkbox"/> 3 Days	<input type="checkbox"/> 3 Days	<input type="checkbox"/> 3 Days	<input type="checkbox"/> 3 Days	<input type="checkbox"/> 3 Days	<input type="checkbox"/> 3 Days
	<input type="checkbox"/> 6 Days	<input type="checkbox"/> 6 Days	<input type="checkbox"/> 6 Days	<input type="checkbox"/> 6 Days	<input type="checkbox"/> 6 Days	<input type="checkbox"/> 6 Days
<i>*(HIP option must follow base option.)</i>	Modal Premium \$ _____			Modal Premium \$ _____		
Critical Accident Rider	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000			<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000		
	Modal Premium \$ _____			Modal Premium \$ _____		
Dental and Vision 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		
	Modal Premium \$ _____			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 \$20 Policy Fee*

## Step 3: Pre-Qualification and Medical Information

*If any answer to questions 1-3 is YES (or 1-4 if applying for Option C), do not submit the application.*

	Applicant 1	Applicant 2
1. Is the applicant currently (i) living in a nursing home or assisted living facility or (ii) receiving home health care or similar type of care?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Does the applicant require the assistance or supervision of another person or a device of any kind for any one of the following routine Activities of Daily Living (bathing, dressing, eating, continence, toileting or transferring to or from a bed or chair)?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
3. Within the past 12 months has the applicant been diagnosed as having, been prescribed medication for, or received medical advice or treatment from a licensed healthcare professional for Alzheimer's disease, dementia, or memory loss?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<b>If applying for Option C:</b>		
4. In the next 60 calendar days, is the applicant (i) scheduled for or (ii) anticipating the scheduling of:		
A. Admission to a hospital, nursing home or assisted living facility; or	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
B. Home health care services; or		
C. Surgery?		

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).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", for which Company? Applicant 1 _____ Applicant 2 _____		

**ACKNOWLEDGMENTS & 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**

I hereby apply to Guarantee Trust Life Insurance Company ("GTL") for a policy to be issued in reliance on my answers to the questions in this application for insurance coverage ("Application"). I have read or had read to me the completed Application and I represent that all statements made in this Application and all answers to the medical questions contained in the Application are full, complete and true, to the best of my knowledge and belief. I UNDERSTAND THAT ANY FALSE STATEMENTS OR MISREPRESENTATIONS MAY RESULT IN LOSS OF INSURANCE IF SUCH FALSE STATEMENT MATERIALLY AFFECTED EITHER THE ACCEPTANCE OF THE RISK OR THE HAZARD ASSUMED BY THE COMPANY. I understand that any changes in my health conditions, 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 waived any conditions of this Application. I acknowledge I have received or will receive the following in conjunction with my Application: (1) the Outline of Coverage, (2) Notice of Privacy Practices, (3) the Pre-Notice which describes how information is obtained and used by GTL, and (3) *A Guide to Health Insurance for People with Medicare* and the Medicare Duplication of Benefits Disclosure, if eligible for Medicare.

**Applicant Authorization to Obtain and Disclose Medical Information for Underwriting and Claim Purposes ("Authorization")**

I hereby authorize any physician, healthcare professional, hospital, clinic, Veterans Administration or other medical or medical-related facility, pharmacy, pharmacy benefit management company or prescription data base service, insurance carrier, consumer reporting agency, or insurance support organization that has records or knowledge of my past or present health, prescription drug or medication history, other insurance coverage, and criminal or motor vehicle records to give to GTL, and representatives performing services for GTL including its employees, third-party administrators, insurance support organizations, or its reinsurer(s), any such information. This excludes psychotherapy notes. Such information about me may be disclosed to GTL and to any representatives performing services for GTL related to this Application and any policy subsequently issued related thereto ("Policy"). I agree to notify GTL of any change in my health, prescription drug or medications while my Application is in the underwriting process.

I agree this Authorization may also be used to obtain health, prescription drug and/or medication information or records, as stated above, in order to process a claim that is submitted within the timeframe this Authorization remains valid.

I have the right to revoke this Authorization at any time by sending a written request to GTL at 1275 Milwaukee Avenue, Glenview, IL 60025. Attention: Policy Owner Services. I understand revocation of my Authorization will not be effective to the extent GTL has relied on the use or disclosure of my health, prescription drug and/or medication information or so long as GTL has a legal right to contest a claim under the Policy. I understand my Application for insurance can be declined if I choose not to sign this Authorization.

I further understand any protected health information disclosed pursuant to this Authorization, will be protected by GTL in accordance with federal and/or applicable state privacy laws, including but not limited to the Health Insurance Portability and Accountability Act of 1996, as amended.

**Electronic Transactions, Electronic Signatures, Policy Fulfillment and Communications**

This Application may be completed by electronic device or telephonic means. I acknowledge GTL or the agent has verified my identity in accordance with any applicable federal or state law and that if this Application is completed by electronic means, I have provided my consent and authorization to complete an electronic transaction to apply for this coverage. My electronic signature is legally binding, and has the same effect as if I had physically signed this Application. I agree that I may receive my Policy and other GTL communications electronically. I also 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 Communications and receive a paper copy of my Policy free of charge.

**Any person who knowingly presents a false or fraudulent claim, for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.**

**Applicant 1 Signature:** \_\_\_\_\_

**Signed at:** City and State: \_\_\_\_\_ **Date:** \_\_\_\_\_

**Applicant 2/Spouse Signature:** (if applicable) \_\_\_\_\_

**Signed at:** City and State: \_\_\_\_\_ **Date:** \_\_\_\_\_



## 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.

Bank Routing #: \_\_\_\_\_ Account #: \_\_\_\_\_

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 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

**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](mailto: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**