GTL | GUARANTEE TRUST LIFE

Application to Guarantee Trust Life Insurance Company for Cancer, Heart Attack and Stroke Insurance
1275 Milwaukee Avenue Glenview, IL 60025 (800) 338-7452

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

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

SECTION I APPLICANT(S) INFORMATION **SEND DOCUMENTS TO:** ☐ **AGENT** ☐ **INSURED**

Applicant 1

Last Name _____ First Name _____ M.I. _____

Social Security # _____ ☐ Male ☐ Female Age _____ Date of Birth _____

Weight _____ lbs. Height _____ ft. _____ in.

Have you used any tobacco products in the last 12 months? ☐ Yes ☐ No

Requested Effective Date _____ Requested Draft Date _____
Draft day cannot be more than 10 days before or after the effective date.

Beneficiary's Full Name _____ Relationship _____

Applicant 2

Last Name _____ First Name _____ M.I. _____

Social Security # _____ ☐ Male ☐ Female Age _____ Date of Birth _____

Weight _____ lbs. Height _____ ft. _____ in.

Have you used any tobacco products in the last 12 months? ☐ Yes ☐ No

Requested Effective Date _____ Requested Draft Date _____
Draft day cannot be more than 10 days before or after the effective date.

Beneficiary's Full Name _____ Relationship _____

Dependents *(If more than two children are proposed for insurance, please attach a separate sheet.)*

Last Name _____ First Name _____ M.I. _____

☐ Male ☐ Female Age _____ Date of Birth _____

Last Name _____ First Name _____ M.I. _____

☐ Male ☐ Female Age _____ Date of Birth _____

Contact Information

Home Address _____

City _____ State _____ Zip Code _____

Telephone # _____ Email Address _____

SECTION II – COVERAGE SELECTION & PREMIUMS

Premium Payment Mode	Applicant 1 ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly		Applicant 2 ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly	
CANCER COVERAGE				
Lump Sum Cancer Coverage	Benefit Amount $_____	Modal Premium $_____	Benefit Amount $_____	Modal Premium $_____
Cancer Recurrence Benefit Rider	☐	Modal Premium $_____	☐	Modal Premium $_____
Cancer Benefit Builder Rider *(Includes Skin Cancer and Annual Wellness Benefits)*	☐	Modal Premium $_____	☐	Modal Premium $_____
Child Cancer Benefit Rider	Benefit Amount $_____	Modal Premium $_____		
HEART ATTACK/STROKE COVERAGE				
Lump Sum Heart Attack/Stroke Coverage	Benefit Amount $_____	Modal Premium $_____	Benefit Amount $_____	Modal Premium $_____
Heart Attack/Stroke Recurrence Benefit Rider	☐	Modal Premium $_____	☐	Modal Premium $_____
Heart Attack/Stroke Benefit Builder Rider	☐	Modal Premium $_____	☐	Modal Premium $_____
Child Heart Attack/Stroke Benefit Rider	☐ $5,000 ☐ $10,000	Modal Premium $_____		
Intensive Care Benefit Rider	☐ $150 ☐ $450 ☐ $300 ☐ $600	Modal Premium $_____	☐ $150 ☐ $450 ☐ $300 ☐ $600	Modal Premium $_____
Critical Accident Benefit Rider	☐ $5,000 ☐ $10,000	Modal Premium $_____	☐ $5,000 ☐ $10,000	Modal Premium $_____
Dental/Vision Benefit Rider	☐ $400 ☐ $800 ☐ $1,200	Modal Premium $_____	☐ $400 ☐ $800 ☐ $1,200	Modal Premium $_____
Sub Total: Base plus riders	$_____		$_____	
Return of Premium Benefit Rider	☐ 20 Year ☐ ROP at Death ☐ ROP at Death Prior to 86	ROP Factor _____	☐ 20 Year ☐ ROP at Death ☐ ROP at Death Prior to 86	ROP Factor _____
Modal Premium *(Multiply sub total by ROP factor)*	$_____		$_____	
Annual Policy Fee *(modalize if needed), if applicable*	$_____		$_____	
Total Modal Premium	$_____		$_____	

SECTION III – HEALTH QUESTIONS	APPLICANT 1	APPLICANT 2	DEPENDENT(S)
1. In the past 5 years has any person to be insured been diagnosed or treated by a medical professional for an Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)? (The reporting of any HIV test results is limited to FDA-licensed tests, and you need not report results of tests conducted at an anonymous counseling and testing site or through the use of a home test kit.)	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
For Questions 2 through 5, 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:	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
2. Chronic Obstructive Pulmonary/Lung Disease (COPD/COLD), Emphysema or Chronic Bronchitis requiring the use of two or more medications or oxygen therapy?			

If YES for 1 or 2, that person is not eligible for any coverage.

If dependent(s) answered YES, please provide name of dependent(s) _____

CANCER COVERAGE (complete if applying for Cancer benefits and/or Cancer Benefit Builder Rider and/or Intensive Care Benefit Rider)

3. Leukemia, Hodgkin's or Non-Hodgkin's disease, lymphoma, malignant melanoma, or any internal cancer, a pre-leukemic or pre-malignant condition?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
4. PSA reading greater than 4.0 or abnormal mammogram test results where cancer has not been ruled out?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If YES for 3 or 4, that person is not eligible for Cancer Coverage.

If dependent(s) answered YES, please provide name of dependent(s) _____

HEART ATTACK/STROKE COVERAGE
(complete if applying for Heart Attack/Stroke benefit and/or Heart Benefit Builder Rider and/or Intensive Care Benefit Rider)

5. Heart attack, heart bypass, angioplasty, stent placement, coronary artery disease, angina, heart disease, congestive heart failure, pacemaker or defibrillator, heart arrhythmia, peripheral vascular disease, carotid artery disease, stroke, Transient Ischemic Attack (TIA), aortic valve disease or in the past 6 months had a blood pressure reading greater than 150 systolic or 95 diastolic?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
6. Has any person applying for coverage had diabetes treated with insulin before age 45?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
7. Has any person applying for coverage had diabetes treated with insulin starting at age 45 or older?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If YES for 5 or 6, that person(s) is not eligible for Heart Attack/Stroke coverage. For question 7, if YES, that person(s) may be eligible for coverage with modified benefits.

If dependent(s) answered YES, please provide name of dependent(s) _____

ALL APPLICANTS MUST ANSWER #8

8. For any of the medical conditions listed above, within the past 24 months, has any person to be insured had any abnormal diagnostic test results, is 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 has not yet done so?	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

If YES, that person is not eligible for any coverage.

If dependent(s) answered YES, please provide name of dependent(s) _____

SECTION IV – REPLACEMENT OF EXISTING COVERAGE	APPLICANT 1	APPLICANT 2
1. Will any existing specified disease or other accident and health insurance be replaced or changed if the proposed coverage is issued? (If "YES," please complete the Replacement Form, if required in your state.) *If "YES*," with which company? (Applicant 1) _____ *If "YES*," with which company? (Applicant 2) _____	☐ Yes ☐ No	☐ Yes ☐ No

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) Email Address Agent Code

Agent's Signature Date

APPLICANT ACKNOWLEDGEMENTS

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, INTENTIONAL 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, pharmacies or pharmacy-related facility which have 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 this authorization will be valid for 24 months from the date signed. 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.

I (We) agree that I (we) may receive my (our) policy and other GTL correspondence in electronic format. 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.

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

Applicant 1 Signature: _____

Signed at: City and State: _____ Date: _____

Applicant 2 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.

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 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(s) of insured(s) 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
MAKE CHECK PAYABLE TO: GUARANTEE TRUST LIFE INSURANCE COMPANY

---------- *Detach this Notice to Applicant 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 confi dential 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 fi le. 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.

GTL | GUARANTEE TRUST LIFE

Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, Illinois 60025

GUARANTEE TRUST LIFE INSURANCE COMPANY
Electronic Delivery and Communications Disclosure

Unless otherwise requested by you, all documents that form our insurance relationship will be provided to you in electronic format. These documents include:

- Application(s) and related forms
- Policy or certificate insurance fulfillment documents
- Disclosures, where required by state and / or federal law

In order to access the documents electronically, you will need to:

1. Have access to the internet and be able to view, save and print PDF files (such as Adobe® Reader® 5.0 or higher.)
2. Maintain a valid designated e-mail address. (We reserve the right to validate the e-mail address you provide us.)

You are responsible for accessing, opening and reading communication we send in electronic format. We will consider Electronic Communications to be received by you upon successful delivery to the designated e-mail address you provide. To ensure our Electronic Communications are not blocked in e-mail or spam filters, please add our domain, "gtlic.com", to your safe sender list.

Access to Paper Copies

To ensure you have them when you need them, you should print copies of the documents we send through Electronic Communication. However, you may request from us one paper copy of your policy / certificate fulfillment package free of charge. Except where prohibited by law, we may charge a nominal fee for additional copies requested after the first. You may contact us with your request in writing, by phone, or email as indicated in our Company Contact Information, shown below.

Our Right to Send Paper

We reserve the right to provide paper copies in lieu of Electronic Communication. We would do this in the event of, but not limited to, a system outage, if we suspect fraud, or where the designated email address you have provided to us does not accept emails from us.

Changes to the Terms and Conditions of Electronic Communication

At our discretion, we reserve the right to modify the terms and conditions stated herein. This includes modifying the terms to include additional instances for Electronic Communication other than policy or certificate fulfillment. If we do, we will provide you with notice of such change, its effective date electronically and your choices under the new terms and conditions.

Withdrawal of Consent

You may elect to withdraw your Consent for Electronic Delivery and Communications at any time by contacting us in writing, by phone, or through the Customer Service link on our website. Please see 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 Policyholder tab at the top of the screen. Choose "Customer Service" from the list of options to communicate with us.