Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, Illinois 60025
1-800-338-7452

Application for: Recover Cash — Short-Term Nursing Home Care Indemnity Insurance

SEND DOCUMENTS TO: ○ AGENT ○ INSURED

APPLICATION FOR: ○ New Coverage ○ Increase of Benefits ○ Reinstatement

If increase of benefits or reinstatement is requested, please list GTL policy/certificate number(s) : _____

Proposed Insured 1

First Name_____ M.I. _____ Last _____

Home Address _____ City_____ State_____ Zip_____

Phone (___) _____ ○ Mobile E-mail Address _____

Soc. Security # _____ Age ____ Date of Birth _____/_____/_____ ○ Male ○ Female

Height_____ft. _____ in. Weight _____lbs. Occupation _____

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

Proposed Insured 2

First Name_____ M.I. _____ Last _____

Home Address _____ City_____ State_____ Zip_____

Phone (___) _____ ○ Mobile E-mail Address _____

Soc. Security # _____ Age ____ Date of Birth _____/_____/_____ ○ Male ○ Female

Height_____ft. _____ in. Weight _____lbs. Occupation _____

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

Secondary Addressee

You have the right to designate an additional person to also receive notices of lapse or termination of the policy for nonpayment of premium. If you wish to designate such a person, please complete below.

Name _____ Relationship _____

Address _____

If you wish to designate at a later date, you must submit a written request with the name and address of the third-party designee.

Beneficiary Information

Please provide Beneficiary information below:

_____
Full Legal Name of Beneficiary — Relationship to Proposed Insured 1

_____
Full Legal Name of Beneficiary — Relationship to Proposed Insured 2

Proposed Insured Coverage Information

	Proposed Insured 1	Proposed Insured 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).	OYes ONo	OYes ONo

If "Yes", with which company? (Proposed Insured 1)_____

If "Yes", with which company? (Proposed Insured 2)_____

Plan Selection and Payment Information

	Proposed Insured 1	Proposed Insured 2
▶ **Nursing Home/Assisted Living Facility**		
Select Daily Benefit Amount: $50–$300/day (in $10 increments)	$_____	$_____
Benefit Period:	O 30 O 45 O 60 O 90 O 180 O 360	O 30 O 45 O 60 O 90 O 180 O 360
Elimination Period:	O 0 Days O 20 Days	O 0 Days O 20 Days
Optional Riders:		
▶ **Inflation Rider** (Applies to Nursing Home and Assisted Living Facility Benefits only.)	O 5% Simple Inflation O 5% Compound Inflation	O 5% Simple Inflation O 5% Compound Inflation
▶ **Home Health Care and Caregiver Benefit Riders** (Caregiver Benefit is $3,500 Lump Sum.)		
Select Weekly Benefit Amount: $50 - $1,400/week (in $50 increments)	$_____	$_____
Benefit Maximum:	O 26 Weeks O 52 Weeks	O 26 Weeks O 52 Weeks
Elimination Period:	O 0 Days O 20 Days	O 0 Days O 20 Days

Modal Premium:

O Monthly Bank Draft (0.084) O Quarterly (0.26)
O Semi-Annual (0.515) O Annual

Requested Draft Day: 1st-28th _____
OR O 2nd Wednesday O 3rd Wednesday O 4th Wednesday

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

Proposed Insured 1 Modal Premium: $_____
Proposed Insured 2 Modal Premium: $_____
Proposed Insured 1 Annual Policy Fee: $_____
Proposed Insured 2 Annual Policy Fee $_____
Total Premium: $_____

Medical Questions

If the answer to any part of questions 1-4 is "YES", the respective proposed insured is not eligible for coverage.	Proposed Insured 1	Proposed Insured 2
1. Is any proposed insured currently eligible for Medicaid, on early Medicare due to disability (prior to age 65) or disabled?	OYes ONo	OYes ONo
2. In the past 10 years has any proposed insured been diagnosed as having, been prescribed medication by a medical professional for or received medical advice or treatment from a member of the medical profession for Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection ?	OYes ONo	OYes ONo
3. In the past 24 months, has any proposed insured been diagnosed as having, been prescribed medication by a medical professional for or received medical advice or treatment from a member of the medical profession for:		
a. Stroke, Transient Ischemic Attack (TIA), congestive heart failure, heart or valve surgery, or an organ transplant (other than corneal)?	OYes ONo	OYes ONo

	Proposed Insured 1	Proposed Insured 2
b. Insulin dependent diabetes, diabetes with neuropathy, or eye or kidney complications?	OYes ONo	OYes ONo
c. Alzheimer's disease, dementia, memory loss, Parkinson's disease, psychotic disorders, systemic lupus, Multiple Sclerosis, Muscular Dystrophy, cerebral palsy, or ALS (Lou Gehrig's disease)?	OYes ONo	OYes ONo
d. Cancer (other than skin cancer), leukemia, lymphoma or malignant melanoma, or cancer that has spread from its original site?	OYes ONo	OYes ONo
e. Chronic Obstructive Pulmonary Disease (COPD), Chronic Obstructive Lung Disease (COLD), emphysema, respiratory failure or do you require daily oxygen therapy?	OYes ONo	OYes ONo
f. Liver, kidney, or pancreatic disease?	OYes ONo	OYes ONo
g. Substance use disorder (alcohol or drug abuse)?	OYes ONo	OYes ONo
h. Crippling or rheumatoid arthritis?	OYes ONo	OYes ONo
i. An inability to control bowel or bladder function?	OYes ONo	OYes ONo
j. Any type of amputation?	OYes ONo	OYes ONo
4. In the past 24 months, has any proposed insured:		
a. Required 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)?	OYes ONo	OYes ONo
b. Been advised by a medical professional to enter or been confined to a rehabilitation facility, nursing home or assisted living facility, or received home health care services or similar type of care?	OYes ONo	OYes ONo
c. Been advised by a medical professional to have medical tests, treatment, or surgery that has not been performed or for which results have not been given?	OYes ONo	OYes ONo
5. Has any proposed insured taken any prescription medications during the past 6 months? If yes, complete medication chart below:	OYes ONo	OYes ONo

Name	Medication	Reason Prescribed	Name, Address of Doctor

Acknowledgements & Authorization to Release Medical Information

THIS IS ASUPPLEMENT TO HEALTH INSURANCE AND IS NOT ASUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Proposed Insured 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 innocent, negligent or fraudulent (i) omissions, (ii) misrepresentations or (iii) misstatements could result in a reduction of benefits or denial of an otherwise valid claim, or rescission of the insurance coverage. 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 (4) A Guide to Health Insurance for People with Medicare and the Medicare Duplication of Benefits Disclosure, if eligible for Medicare.

Proposed Insured 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 medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually transmitted diseases, unless otherwise restricted by state law. This Authorization 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 also understand GTL, or its authorized representatives, may conduct a phone interview or face-to face assessment with any proposed insured as part of the underwriting process. Such health, prescription drug and/or medication information will be used to consider my insurability with GTL. I agree and understand this Authorization will be valid for twenty-four (24) months from the date signed below and I, or my authorized representative (if applicable), are entitled to a copy of it. 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. However, I further understand that if a person or entity who receives this information is not covered by federal privacy regulations, the information may be re- disclosed by such person or entity and will likely no longer be protected by the federal privacy regulation.

Electronic Transactions, Electronic Signatures, Policy Fulfillment and Communications

This Application may be completed by electronic device or telephonic means. I acknowledge GTL or its 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. If this Application is completed by telephonic means, I authorize GTL or its agent to accept my voice signature response as having 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.

Fraud Notice: 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, any information or fact material thereto commits a fraudulent act, which is a crime and may be reported as such to the appropriate governmental authorities.

Signature of Proposed Insured 1_____ Date:_____

Signature of Proposed Insured 2_____ Date:_____

Signed at: City and State: _____ Date: _____

Agent's Statement

I certify that I have accurately recorded the information supplied by the proposed insured(s). 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 proposed insured(s) not to withhold any information relative to this application and its questions. I have advised the proposed insured(s) 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 Signature, if applicable	Secondary Agent's Signature, if applicable
Agent's Name (please print)	Agent's Name (please print)
Agent Code Commissions Split (if applicable)	Agent Code Commissions Split (if applicable)
Agent's E-mail Address	Agent's E-mail Address

APPH1-22 (Rev. 4/23)-IA

Monthly Pre-Authorization 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)

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 Here

Receipt Date_____

Received from _____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