GTL | GUARANTEE TRUST LIFE

Application to Guarantee Trust Life Insurance Company
for Precision Care Cancer Insurance
1275 Milwaukee Avenue Glenview, IL 60025 (800) 338-7452

Application for New Coverage

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 15 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 15 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
COVERAGE		
Lump Sum Cancer *(Includes Precision Medicine Benefit)*	Benefit Amount $_____ *(in $5,000 increments)* Modal Premium $____	Benefit Amount $_____ *(in $5,000 increments)* 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 $____	

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 applicable*	$_____	$_____
Total Modal Premium	$_____	$_____

SECTION III – HEALTH QUESTIONS	APPLICANT 1	APPLICANT 2	DEPENDENT(S)
For Questions 1 through 4, 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:			
1. Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS Related Complex (ARC)?	☐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?	☐Yes☐ No	☐Yes☐ No	☐Yes☐ No
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
5. 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, 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 for question 1, 2, 3, 4 or 5 that person is not eligible for 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 Signature, if applicable	Secondary Agent's Signature, if applicable
Agent's Name (please print) Agent Code	Agent's Name (please print) Agent Code
Agent's E-mail Address	Agent's E-mail Address

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 or solicit another to defraud an insurer: (1) by submitting an application or (2) by filing a claim containing a false statement as to any material fact, may be violating state law.

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

OREGON INDIVIDUAL HEALTH INSURANCE POLICY
DISCLOSURE STATEMENT

_____
(Agent or insurance company representative)

_____
(Address)

Completed this questionnaire on _____ for
(Date)

_____
(Applicant)

_____
(Address)

describing _____
(Policy name, form number)

an individual health insurance policy providing coverage for _____

_____

_____

This policy is underwritten by
Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, IL 60025

NOTICE

This disclosure statement answers questions consumers often ask about health insurance coverage and costs. It highlights some of the important issues that frequently affect consumers. It is intended for your use whether you are purchasing health insurance for the first time or whether you are replacing or adding to your existing coverage or whether you are replacing or adding to your existing coverage.

Are *You Considering Replacing Your Current Coverage?* Before you replace your current policy with another, you should review both policies in order to determine whether replacement is in your best interests. The new coverage may be different in important respects. You should be aware of these differences, whether they are temporary or permanent. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy.

Are You Considering Adding to Your Current Coverage? Before you add new coverage to your current coverage, you should review both policies to ensure that you are not purchasing unnecessary coverage. If you obtained your current policy from another agent or a representative of another company, be sure to ask that agent or representative any questions you may have about that policy and the need for additional coverage.

Questions? Ask for Help. If you have any questions that are not answered by this disclosure statement, be sure to ask your agent or insurer representative.

Read Your Policy! If you purchase the offered policy, read it carefully as soon as you receive it. Because it is an individual policy, you will have an opportunity to send it back and obtain a premium refund.

Fill Out Your Application Carefully! Be sure to fill out all portions of your application completely and truthfully. If misstatements are made or information about your health are omitted from the application, the insurer may void the policy or deny your claims, if your age is misstated, the amounts payable on claims may be reduced.

We hope this disclosure statement will help you with your insurance purchase, However, please note that the statement is not intended to be a part of the policy and that only the language of the policy issued by the insurer is final and binding,

QUESTIONS AND ANSWERS
GENERALLY

1. Does the insurer have a list or doctors or hospitals, or both, under contract that are considered "preferred" or "participating"?
   Yes ☐ (Proceed to next question) NO ☐ (Proceed to question 5)

2. May I use doctors or hospitals that are *not* on the list?
   Yes ☐ (Proceed to next question) NO ☐ (Proceed to question 5)

3. Will I save money by using the doctors or hospitals on the list instead of others?
   YES ☐ NO ☐

4. Will doctors and hospitals on the list accept benefits paid under the policy as full payment and not bill me for the balance (other than for deductibles and co-payments)?
   YES ☐ NO ☐

5. (If the coverage offered is comprehensive major medical) Pregnancy Benefits:

(a) What are the policy's benefits and limitations with respect to pregnancy? (Include such applicable limitations as waiting periods and pre-existing conditions periods)

_____

_____

(b) Will the offered policy cover a pregnancy without complications if the pregnancy is in existence at the time of the policy's issuance?
   YES ☐ NO ☐

Are You Replacing Coverage?

6. If I replace my current policy with another and there is no lapse or gap in coverage, will my enrollment under the old policy count toward meeting any waiting periods under the new policy, such as for pre-existing condition limitations?
   YES ☐ NO ☐

☐ OTHER (Explain) _____

_____

_____

7. Will expenses I incurred under my current policy during the current policy year be credited to the new policy's deductibles?
   YES ☐ NO ☐

8. If I have a health condition existing when the offered policy is issued, will that condition be covered as of the date of issuance?
   YES ☐ NO ☐ If not, when will it be covered?

_____

_____

9. Does the policy contain any dollar limitations on specific benefits?
   YES ☐ NO ☐

Any limits on specific benefits, such as hospitalization?
   YES ☐ NO ☐
   If "YES" to either question, please explain:

_____

_____

C. Are You Adding Coverage to Your Current Policy?

10. If coverage under the new policy duplicates coverage under my current policy, will the new policy pay if my current policy also pays?
    YES ☐ NO ☐

(NOTE: You should ask the agent or company representative who sold you your current policy whether your current policy will pay if the new policy pays.)

Applicant Acknowledgement: _____