

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

Full Legal Name of Contingent Beneficiary



## Application for: Advantage Plus.—A Limited Benefit Policy Providing Hospital Confinement Indemnity Benefits

APPLICATION FOR: O New Coverage O Increase of Benefits O Reinstatement If increase of benefits or reinstatement is requested, please list GTL policy/certificate number(s) affected: \_\_\_\_\_ SEND DOCUMENTS TO: O AGENT O INSURED Applicant 1 — First Name M.I. Last Name Soc. Security # \_\_\_\_\_\_ Age \_\_\_ Date of Birth \_\_\_\_\_/\_\_\_ O Male O Female Applicant 1 Primary Phone Number\_\_\_\_\_\_O Mobile **Address** Number & Street \_\_\_\_\_ \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_ If applying for the Critical Accident Rider, please provide Beneficiary information below: Full Legal Name of Beneficiary Relationship to Applicant 1 Relationship to Applicant 1 Full Legal Name of Contingent Beneficiary Applicant 2 — First Name \_\_\_\_\_ M.I. \_\_\_\_ Last Name \_\_\_\_ Soc. Security # \_\_\_\_\_\_ Age \_\_\_ Date of Birth \_\_\_\_/\_\_\_ O Male O Female Applicant 2 Primary Phone Number\_\_\_\_\_\_O Mobile E-Mail Address If applying for the Critical Accident Rider, please provide Beneficiary information below: Full Legal Name of Beneficiary Relationship to Applicant 2

Relationship to Applicant 2

## Pre-Qualification, Medical Information & Exclusions –

If any answer to questions 1 through 5 is Yes, you are not eligible for coverage.

IF EITHER APPLICANT IS BETWEEN THE AGES OF  $64 \frac{1}{2}$  and 70 AS OF THE DATE OF THIS APPLICATION, SKIP QUESTIONS 1 THROUGH 5 UNDER THE ADVANTAGE PLUS LIMITED BENEFIT HOSPITAL CONFINEMENT INDEMNITY POLICY SECTION OF THIS APPLICATION.

NOTE: Pre-existing Condition limitations apply without regard to answering questions 1 through 5 under the Advantage Plus Limited Benefit Hospital Confinement Indemnity Policy section of this Application.

Ad۱	vantage Plus Limited Benefit Hospital Confinement Indemnity Policy —	Applicant 1	Applicant 2
1.	In the past 3 months has either Applicant been confined as an inpatient to a hospital or nursing home or received any home health care services?	OYes ONo	OYes ONo
2.	In the past 12 months has either Applicant had, been treated for or been diagnosed by a medical professional as having a heart attack, congestive heart failure, stroke, Transient Ischemic Attack (TIA), heart surgery/bypass, Peripheral Vascular Disease, malignant melanoma or cancer (other than skin cancer)?	OYes ONo	OYes ONo
3.	In the past 12 months has either Applicant had, been treated for or been diagnosed by a medical professional as having Chronic Obstructive Pulmonary/Lung Disease (COPD/COLD), emphysema, chronic bronchitis, diabetes treated with insulin, dementia, Alzheimer's disease, or chronic liver or chronic kidney disease?	OYes ONo	OYes ONo
4.	In the past 12 months has either Applicant been advised by a medical professional to have surgery which will require an inpatient stay but have not yet done so?	OYes ONo	OYes ONo
5.	Has either Applicant ever been treated for or been diagnosed by a medical professional as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or Human Immunodeficiency Virus (HIV) infection?	OYes ONo	OYes ONo

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Plan Selection and Payment Informat	ion ———						
Daily Hospital Confinement		Α	pplicant 1		Α	pplicant 2	2
Choose an amount in \$10 increments			\$			\$	
Daily Benefit for a 1 day plan from \$1,00 Daily Benefit for a 3, 4, 5, 6, 7, 8, 9, 10 of from \$100 to \$750		Ве	nefit Amou Per Day	ınt		efit Amou Per Day	nt
ποπι φ100 το φ7 30			<b>o</b> 3 <b>o</b> 4			<b>o</b> 3 <b>o</b> 4	
► Select number of Benefit Period Days			<b>o</b> 7 <b>o</b> 8 <b>o</b> 15	<b>O</b> 9	06 ( 010 (	<b>)</b> 7 <b>0</b> 8	<b>O</b> 9
Optional Riders ————————————————————————————————————		<b>O</b> 10			0 10 0		
	Applican	t 1			Арр	licant 2	
<b>N</b> A L L C : D CLD:L	O \$50 O \$100 O S	\$150 0 \$	200	0 \$50	0 \$100	0 \$150	0 \$200
► Ambulance Service Benefit Rider (Maximum Issue Age is 80)	O \$250 O \$300 O Benefit Amount per Am					0 0 \$35 er Ambulan	0 O \$400 ce Service
► Critical Accident Benefit Rider	O \$5,000 O \$10,000		0	\$5,000	0 \$10,	000	
► Lump Sum Hospital Benefit Rider (Not available if the 1 Day Benefit Period is chosen.)	O \$250 O \$500 O	\$750	0	\$250	O \$500	O \$750	
► Ambulatory Surgical Benefit Rider	O \$250 O \$500 O \$	5750 O \$	1,000 0	\$250	O \$500	O \$750	O \$1,00
Total Annual Premium Advantage Plus:	\$				\$		_
Choose Premium Payment Mode							
Premium Mode:		Premi	ums				
O Monthly Bank Draft (.084) O Quarterly (.265)		Applica	nt 1 Total Pi	emium:	\$		
O Semi-Annual (.520) O Annual		Applica	nt 2 Total Pi	remium:	\$		
		Applica	nt 1 Annual	Policy F	ee: \$		
Please Choose a Draft Option:		Applica	nt 2 Annual	Policy F	ee: \$		
Requested Draft Day: 1st-28th		Total Pi	remium: \$_				
<b>OR</b> O 2nd Wednesday O 3rd Wednesday O 4 <sup>th</sup>	<sup>h</sup> 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.)

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.  Permit in required in your state.  If "Yes," with which company? (Applicant 1).  If "Yes," with which company? (Applicant 2).  Acknowledgements & Authorization  THIS IS ASUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE TO OTHER MINIMUM ESSENTIAL COVERAGE MAY RESULT IN AN ADDITIONAL PRIMENT WITH YOUR TAXES.  Applicant Acknowledgements.  Inereby apply to Guarance Thus Life insurance Company? (TLI) for a policy to be issued in reliance on my answers to the questions in this application for insurance accessing. Who agent or either complete in language that all adult-ments make 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 unerstand it is insurance, prolifered in minimum 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 unerstand it is insurance accessing. Who agent or other representative of citil and adult-ments make in this Application and all answers to the medical questions of the insurance accessing. Who agent or other representative of citil and adult-ments make in this Application and all makes to the complete and true, to the best of my knowledge and belief. I unerstand it is incored. Prolifer of the insurance accessing. Who agent or other representative of citil has required, permitted, or encouraged in its otherwise wild claim, or resident or the adult of minimum and an adult in more interests of the insurance accessing. Who agent to access and (3) A Cubic to Medicine Department, or encouraged in its belief in the medicare Duplication of Benefits Disclosure, if eligible for Medicare and the Medicare Duplication of Benefits Disclosure, Peliciple of the Application	Applicant(s) Coverage Information			
If "Yes", with which company? (Applicant 2)			Applicant 1	Applicant 2
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MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES. Applicant. Acknowledgements Thereby apply to Guarantee "Trust Life insurance Cornpany" (GTL) for a policy to be issued in reliance on my answers to the questions in this application for insurance coverage (Paylications). 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 wooledge and belief. I understand that innocent, negligent or fraudulent (i) omissions, (i) misrepresentations or (ii) misstatements could result in a reduction of benefits or denial of an otherwise valid claim, or recisions on of the insurance coverage. No agent or other representations of GTL has required for whole degree of the properties of the production of the control of the production of Benefits Disclosure, if eligible for Medicare.  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 foederal 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.  Fraud Notice: Any person who knowingly and with intent to defraud any insurance company or other person files an Application for insu	Acknowledgements & Authorization			
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statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto may be guilty of insurance fraud as determined by a court of law.  Applicant Signature Section  Applicant 1 Signature:  Signed at: City and State:  Date:  Date:  Date:  Electronic Consent  (we) agree that I (we) may receive my (our) policy and other Company 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 my (our) policy, free of charge.  I decline to give consent to the Company to receive my (our) policy and other Company correspondence in electronic format. I (we) acknowledge receipt of the Electronic Delivery and Communications Disclosure, which describes the requirements for Electronic Policy Fulfillment and receive a paper copy my (our) policy, free of charge.	This Application may be completed by electronic device or telephonic mea with any applicable federal or state law and that if this Application is complete an electronic transaction to apply for this coverage. My electronic signed this Application. If this Application is completed by telephonic means,	ns. I acknowledge GTL or its eted by electronic means, I ha c signature is legally binding,	ve provided my conse and has the same effe	ent and authorization to ect as if I had physically
Applicant 1 Signature:  Signed at: City and State:  Applicant 2/Spouse Signature: (if applicable)  Signed at: City and State:  Date:  Date:  Electronic Consent    (we) agree that I (we) may receive my (our) policy and other Company correspondence in electronic format. I (we) acknowledge receipt of the Electronic Delivery and Communications Disclosure, which describes the requirements for Electronic Poly Fulfillment and Communications, as well as my (our) right to opt-out of Electronic Policy Fulfillment and receive a paper copy my (our) policy, free of charge.  I decline to give consent to the Company to receive my (our) policy and other Company correspondence in electronic format.	statement of claim containing any materially false information or conceals	, for the purpose of misleadi		
Signed at: City and State:	Applicant Signature Section			
Applicant 2/Spouse Signature: (if applicable)	Applicant 1 Signature:			
Applicant 2/Spouse Signature: (if applicable)	Signed at: City and State:	Date:		
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Signature of Applicant 1 Date Signed at City and St	$\ \square$ I decline to give consent to the Company to receive my (our	r) policy and other Comp	oany corresponder	nce in electronic forma
	Signature of Applicant 1	Date	9	Signed at City and State
Signature of Applicant 2 Date Signed at City and Sta	Signature of Applicant 2	Date	Ci	aned at City and State

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## **Agent's Statement**

I certify that I have accurately recorded the information supplied by the Applicant(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 applicant(s) not to withhold any information relative to this application and its questions. I have advised the applicant(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 (plea	ase print)	Agent's Name (plea	ase print)		
Agent Code	Commissions Split (if applicable)	Agent Code	Commissions Split (if applicable		
Agent's E-mail Add	ress	Agent's E-mail Add	ress		

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ΙΟ	My Bank's Address			
Name of My Bank	My Bank's Address	City	State	Zip Code
	request and authorize you to charge t fe Insurance Company, Glenview, Illino			
Bank Routing #:		Account #:		
Account Type O Checkin	ng Account (Attach a Voided "Sample"	check)		
O Savings	Account (Attach a Voided "Sample" ch	eck if applicable, or a	a Deposit slip)	
is to remain in effect until re such requests. I further agr	pect to each payment shall be the same evoked by me in writing and until you re ree that if any such payment is not ho under no liability at all although such a	ceive notice for which onored, whether with	h you agree you will b n or without cause a	pe fully protected in honoring and whether intentionally, o
Printed name of insured if o	different from premium payer	Premium pay	er's signature, as it a	appears on bank records
Printed name of insured if o	different from premium payer	Premium pay	er's signature, as it a	appears on bank records
Printed name of insured if o	different from premium payer	Premium pay	er's signature, as it a	appears on bank records
	different from premium payer			
				·

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