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

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

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

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

SEND DOCUMENTS TO: ○ **AGENT** ○ **INSURED**

Applicant 1

First Name_____M.I. _____ Last Name _____

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

Applicant 1 Primary Phone Number_____ ○ Mobile

E-Mail Address _____

Address

Number & Street _____

City _____ State _____ Zip _____

If applying for the Lump Sum Cancer Rider or Critical Accident Rider, please provide Beneficiary information below:

_____
Full Legal Name of Beneficiary Relationship to Applicant 1

_____
Full Legal Name of Contingent Beneficiary Relationship to Applicant 1

Applicant 2

First Name_____ M.I. _____ Last Name _____

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

Applicant 2 Primary Phone Number_____ ○ Mobile

E-Mail Address _____

If applying for the Lump Sum Cancer Rider or Critical Accident Rider, please provide Beneficiary information below:

_____
Full Legal Name of Beneficiary Relationship to Applicant 2

_____
Full Legal Name of Contingent Beneficiary 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 ½ 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.

Advantage 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

Lump Sum Cancer Rider (To be completed if applying for Lump Sum Cancer Rider)

If any answer to questions 1 through 3 is Yes, you are not eligible for this rider.

	Applicant 1	Applicant 2
1. In the past 5 years has any person to be insured had, been diagnosed as having, or been treated by a medical professional for:		
a. Chronic Obstructive Pulmonary/Lung Disease (COPD/COLD), emphysema or chronic bronchitis requiring the use of two or more medications?	OYes ONo	OYes ONo
b. Leukemia, Hodgkin's Disease, lymphoma, malignant melanoma, sarcoma, or any internal cancer, or had radiation or chemotherapy for any of these conditions or a pre-leukemic condition or a pre-malignant condition?	OYes ONo	OYes ONo
2. In the past 5 years, has any person to be insured had, been diagnosed as having, received medication for, or been treated by a physician or an appropriately licensed clinical professional acting within the scope of his/her license for Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?	OYes ONo	OYes ONo
3. Within the past 24 months, has any person to be insured:		
a. Been advised by a medical professional that a diagnostic test was needed or had any abnormal diagnostic test results?	OYes ONo	OYes ONo
b. Had a symptom or abnormality that would cause a person to seek medical attention or advice?	OYes ONo	OYes ONo

Plan Selection and Payment Information

	Applicant 1	Applicant 2
Daily Hospital Confinement Choose an amount in $10 increments Daily Benefit for a 1 day plan from $1,000 to $2,500 Daily Benefit for a 3, 4, 5, 6, 7, 8, 9, 10 or 15 day plan from $100 to $750	$_____ Benefit Amount Per Day	$_____ Benefit Amount Per Day
▶ Select number of Benefit Period Days	○ 1 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 15	○ 1 ○ 3 ○ 4 ○ 5 ○ 6 ○ 7 ○ 8 ○ 9 ○ 10 ○ 15

Optional Riders

	Applicant 1	Applicant 2
▶ Ambulance Service Benefit Rider (Maximum Issue Age is 80)	○ $50 ○ $100 ○ $150 ○ $200 ○ $250 ○ $300 ○ $350 ○ $400 *Benefit Amount per Ambulance Service*	○ $50 ○ $100 ○ $150 ○ $200 ○ $250 ○ $300 ○ $350 ○ $400 *Benefit Amount per Ambulance Service*
▶ Outpatient Therapy Rider (Choose Calendar Year Benefit of 15 or 30 Days) $50/Day Outpatient Therapy $50/Day Chiropractic care/5 Visits per Year	○ 15 Days or ○ 30 Days	○ 15 Days or ○ 30 Days
▶ Skilled Nursing Facility Benefit Rider (Choose one Option and choose an amount in $10 Increments from $100 to $220)		
Option 1: Benefits payable from Day 1 through 50 OR	○ $_____	○ $_____
Option 2: Benefits payable from Day 21 through 100	○ $_____	○ $_____
▶ Lump Sum Cancer Benefit Rider (Includes $500 Basal Cell/Squamous Cell Skin Carcinoma benefit and 25% Cancer In-Situ Benefit)	○ $2,500 ○ $5,000 ○ $7,500 ○ $10,000 ○ $15,000 ○ $20,000 ○ With 100% Recurrence Benefit	○ $2,500 ○ $5,000 ○ $7,500 ○ $10,000 ○ $15,000 ○ $20,000 ○ With 100% Recurrence Benefit
▶ Critical Accident Benefit Rider	○ $5,000 ○ $10,000	○ $5,000 ○ $10,000
▶ Lump Sum Hospital Benefit Rider (Not available if the 1 Day Benefit Period is chosen.)	○ $250 ○ $500 ○ $750	○ $250 ○ $500 ○ $750
▶ Outpatient Surgical Benefit Rider	○ $250 ○ $500 ○ $750 ○ $1,000	○ $250 ○ $500 ○ $750 ○ $1,000
▶ Dental and Vision Benefit Rider	○ $400 ○ $800 ○ $1,200	○ $400 ○ $800 ○ $1,200
Total Annual Premium Advantage Plus:	$_____	$_____

Choose Premium Payment Mode

Premium Mode:

○ Monthly Bank Draft (.084) ○ Quarterly (.265)
○ Semi-Annual (.520) ○ Annual

Please Choose a Draft Option:

Requested Draft Day: 1st-28th _____

OR ○ 2nd Wednesday ○ 3rd Wednesday ○ 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

Applicant 1 Total Premium: $ _____

Applicant 2 Total Premium: $ _____

Applicant 1 Annual Policy Fee: $_____

Applicant 2 Annual Policy Fee: $_____

Total Premium: $_____

Applicant(s) Coverage Information

	Applicant 1	Applicant 2
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 Form if required in your state.	○Yes ○No	○Yes ○No

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

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

Acknowledgements & 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 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. 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, and (3) *A Guide to Health Insurance for People with Medicare* and the Medicare Duplication 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 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.

Applicant Signature Section

Applicant 1 Signature: _____

Signed at: City and State: _____ **Date:** _____

Applicant 2/Spouse Signature: (if applicable) _____

Signed at: City and State: _____ **Date**: _____

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 (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

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

Duplication of Insurance Form

The state of South Carolina requires this information be completed for persons who are eligible for Medicare by age, or those who have a current Medicaid eligibility card, when applying for new coverage. This form must be completed, signed and dated, and submitted with the application.

Do you presently have any accident and health insurance in force? ☐Yes ☐ No

If yes, please complete the following:

Type of insurance _____ Type of insurance _____

Amount _____ Amount _____

Name of Company _____ Name of Company _____

Policy Number_____ Policy Number_____

Type of insurance _____ Type of insurance _____

Amount _____ Amount _____

Name of Company _____ Name of Company _____

Policy Number_____ Policy Number_____

_____
(Signature of Applicant)

_____
(Date)

If the coverage you are applying for will duplicate some of the benefits of the coverage you already have, please sign and date this form below.

I understand that the insurance I am applying for will duplicate coverage I already have. Even so, I still believe I need this new insurance.

_____ _____
(Witness) (Signature of Applicant)

_____
(Date)