Agent Name:

Phone:

GTL | GUARANTEE TRUST LIFE

Advantage Plus Hospital Indemnity Insurance

APPLICANT INFORMATION PACKET

COLORADO

REQUIRED TO LEAVE WITH APPLICANT

INCLUDES:

- OCG0553-CO - Advantage Plus Hospital Indemnity Outline of Coverage
- MEDDUP-5-CO - Medicare Duplication Notice
- HIPAA- Notice of Privacy Practices
- PRE-NOTICE TO PROPOSED INSURED
- E-CONSENT- Electronic Delivery and Communications Disclosure
- AGENT – Colorado Insurance Producer Compensation Disclosure

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, IL 60025
www.gtlic.com | 800.338.7452

(Rev. 6/22) 15A783

GUARANTEE TRUST LIFE INSURANCE COMPANY
A Mutual Company
1275 Milwaukee Avenue, Glenview, Illinois 60025
(847) 699-0600

HOSPITAL CONFINEMENT BENEFIT POLICY
Guaranteed Renewable for Life
Premiums May Be Changed By Class

OUTLINE OF COVERAGE
For Policy Form G0553-CO
With Optional Rider Forms RG05SNF, RG05LSH
RG05ASB, RG07LS, and RG07OPS

KEEP THIS OUTLINE FOR YOUR RECORDS

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

THIS IS A LIMITED BENEFIT POLICY - READ YOUR POLICY CAREFULLY – This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. Your policy sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

LIMITED BENEFIT COVERAGE – This policy is designed to provide, to persons insured, Limited Benefit Coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Such policies do not provide any benefits other than the fixed daily benefit for hospital confinement and any additional benefits described below.

BENEFITS

We will only pay benefits for Hospital Confinements, Emergency Room Services, and Mental Health Hospital Confinements that are Medically Necessary and begin while the Policy is in force.

BENEFIT A : HOSPITAL CONFINEMENT BENEFIT (INJURY OR SICKNESS)

We will pay the Hospital Confinement Indemnity Benefit Amount shown on the Policy Schedule, for each day You are Hospital Confined due to Injury or Sickness. Benefits are subject to the Maximum Benefit Period, as shown in the Policy Schedule, for any One Period of Confinement as defined in the Policy.

Hospital Confinement Benefit selected: $_____ per day

Maximum Benefit Period selected: □10 days □21 days

BENEFIT B: MENTAL HEALTH BENEFIT

We will pay the Mental Health Benefit Amount, shown in the Policy Schedule, for each day You are Hospital Confined due to a Mental or Nervous Disorder. This benefit is subject to the maximum number of days payable as shown in the Policy Schedule.

BENEFIT C: EMERGENCY ROOM BENEFIT (INJURY ONLY)

We will pay the Emergency Room Benefit shown in the Policy Schedule for services in a Hospital emergency room or Hospital affiliated emergency care facility for loss due to Injury, provided the Emergency treatment is followed within 24 hours by a covered Hospital Confinement of at least one day. This benefit is payable only once per any One Period of Confinement.

We won't pay benefits under both Benefit A and Benefit B above for the same day of Hospital Confinement.

LIMITATIONS AND EXCLUSIONS:

PRE-EXISTING CONDITION LIMITATION

Pre-existing Condition: A Sickness or Injury, disclosed or not disclosed on the application, for which You incurred charges, received medical treatment, consulted a health care practitioner, or took prescription drugs within the 6 month period immediately prior to Your Effective Date of coverage under this Policy.

Pre-existing conditions are not covered unless the loss begins more than 6 months after Your Effective Date of coverage.

EXCLUSIONS

We won't pay benefits for:

1. Treatment, services or supplies which:
   - Are not Medically Necessary;
   - Are not prescribed by a Doctor as necessary to treat an Sickness or Injury;
   - Are determined to be Experimental/Investigational in nature by Us;
   - Are received without charge or legal obligation to pay;
   - Would not routinely be paid in the absence of insurance;
   - Are received from any Family Member unless such person is acting within the scope of his or her license and a charge has been received for the treatment, services or supplies;
   - Are received outside the United States.
2. Expenses incurred as a result of loss due to war, or any action of war, declared or undeclared; service in the armed forces of any country.
3. Expenses incurred as a result of committing or attempting to commit an assault or felony or participating in a riot or civil commotion.
4. Expenses incurred as a result of suicide or intentionally self-inflicted Injury while sane or insane.
5. Injury or Sickness arising out of or in the course of employment or which is compensable under any Workers' Compensation or Occupational Disease Act or Law.
6. Cosmetic surgery other than:
   - Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
   - Reconstructive surgery because of a congenital disease or anomaly.
7. Injury due to being legally intoxicated, as defined by the jurisdiction in which an Accident occurs.
8. Loss due to voluntarily using any drug, narcotic or controlled substance, unless as prescribed by a Doctor.

OPTIONAL COVERAGE(S): (Available for an additional premium)

Skilled Nursing Facility Benefit Rider RG05SNF
We will pay the Skilled Nursing Benefit Amount as shown in the Policy Schedule, for each day You are confined in a Skilled Nursing Facility provided that;

1. You have first been Hospital Confined for 3 or more consecutive days;
2. The Skilled Nursing Facility confinement begins within 30 days after such Hospital Confinement;
3. Your Doctor must certify the need for the Skilled Nursing Facility confinement; and
4. The Skilled Nursing Facility confinement is for the same Injury or Sickness as the Hospital Confinement for which We paid benefits.

The Skilled Nursing Facility Benefit Amount is subject to the Elimination Period and payable only for those days indicated in the Policy Schedule under Skilled Nursing Maximum Benefit Period. We will not pay more than the number of days indicated in the Skilled Nursing Maximum Benefit Period for any One Period of Confinement as defined in the Policy.

Lump Sum Hospital Benefit Rider RG05LSH
We will pay the Lump Sum Hospital Benefit Amount when You are Hospital Confined. Lump Sum Hospital Benefits are payable only;

1. When the Hospital Confinement is covered under the Policy to which this Rider is attached; and
2. Once during any One Period of Confinement.

Lump Sum Hospital Benefit Amount Selected: □$250 □$500 □$750

Ambulance Service Benefit Rider RG05ASB
We will pay the Ambulance Service Benefit Amount, shown on the Schedule, if a licensed surface ambulance service transports you to or from a Hospital to which you are Hospital Confined. This Benefit is payable no more than once per Hospital Confinement for all trips. The Hospital Confinement requiring the ambulance service must be Medically Necessary and covered by the Policy. We will not pay more than the Lifetime Maximum Amount shown on the Policy Schedule.

Lump Sum Cancer Rider RG07LS
We will pay the Lump Sum Benefit Amount provided You have:

1. met the conditions set forth in the Eligibility for Benefits provision of this Rider, and
2. satisfied this Rider's Proof of Loss provision.

The Lump Sum Benefit Amount is shown in the Policy Schedule.
Benefits under this Rider are limited to one (1) Lump Sum payment during Your lifetime.

Lump Sum Cancer Rider Amount Selected: □$2,500 □$5,000 □$7,500 □$10,000

Surgical Benefit Rider RG07OPS
We will pay the Surgical Benefit Amount for a surgical procedure performed by a doctor when such procedure is performed in an Ambulatory Surgical Center or Outpatient Facility of a Hospital. Surgical procedures and the services and supplies related to the surgical procedures are limited to two occurrences per calendar year not to exceed the Maximum Surgical Benefit Amount shown in the Policy Schedule.

Surgical Benefit Rider Exclusions

The following rider exclusions are in addition to the exclusions contained in the Policy to which this Rider is attached. We won't pay benefits for:

1. Surgical procedures performed in a Doctor's office or when Hospital Confined;
2. Surgery for corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical corrections thereof unless due to injury occurring while coverage is in force;
3. Surgery for removal of breast implants. This exclusion shall not apply to the removal of breast implants for the medically necessary treatment of a covered illness or injury, unless the implants were implanted solely for cosmetic purposes and not for surgery performed as reconstruction resulting from an illness or injury.
4. Surgery for non-malignant warts, moles (boils) and lesions unless Medically Necessary;
5. Surgery for sex transformation or reversal thereof
6. Dental surgery except oral surgery for excision of tumors, growths and cysts of the jaw and mouth and surgery to sound natural teeth made necessary by injury.
7. Surgery for refractive anomalies.

Surgical Benefit Rider Amount Selected: □$250 □$500 □$750 □$1,000

GUARANTEED RENEWABLE FOR LIFE You may keep this Policy, and Riders if attached, in force during Your entire lifetime, unless otherwise stated in the Rider, by paying the renewal premium at the intervals available to You at time of renewal. You must pay the renewal premium by its due date or during the 31 days that follow. We cannot cancel or refuse to renew this Policy or place any restrictions on it if You pay Your premiums on time.

PREMIUMS SUBJECT TO CHANGE We may change the premium rates for this Policy/Riders by giving You at least 31 days prior written notice of any change in the renewal premium. We can only change the premium if We change it for all Policies/Riders like Yours in Your state on a class basis.

INITIAL PREMIUM:

Limited Benefit Hospital Policy:	**$_____**
□ **Skilled Nursing Facility Benefit Rider:**	**$_____**
□ **Lump Sum Hospital Benefit Rider:**	**$_____**
□ **Ambulance Service Benefit Rider:**	**$_____**
□ **Lump Sum Cancer Rider:**	**$_____**
□ **Surgical Benefit Rider:**	**$_____**
TOTAL PREMIUM:	**$_____**

IMPORTANT NOTICE TO PERSONS ON MEDICARE THIS IS NOT MEDICARE SUPPLEMENT INSURANCE

THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

Some health care services paid for by Medicare may also trigger the payment of benefits from this policy.

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Hospice
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

This policy must pay benefits without regard to other health benefit coverage to which you may be entitled under Medicare or other insurance.

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

GUARANTEE TRUST LIFE INSURANCE COMPANY

PLEASE GIVE TO PROPOSED INSURED

PRE-NOTICE TO PROPOSED INSURED
I understand that the insurance applied for shall not become effective until: a) approved and issued by GTL; and b) I have been furnished written notice of the effective date. If applicable, I have received the Guide to Health Insurance for people with Medicare and the Outline of coverage.

DO NOT CANCEL EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE OF APPROVAL FROM GTL
In completing this application for insurance, it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties such as family members; business associates; financial sources; friends; neighbors; or others with whom you are acquainted. This inquiry includes information as to your character; general reputation; personal characteristics; and mode of living, whichever may be applicable. You have the right to make written request within a reasonable time period for a disclosure of additional information concerning the nature and scope of the investigation. (See Disclosure Notice.)

NOTICE TO APPLICANT
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 covering 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 confidential and will not be disclosed 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 file. 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 use a “consumer reporting agency,” you have the right to: (1) ask to talk to 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 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.

NOTICE OF INFORMATION PRACTICES
GTL will need to obtain data about you and other persons proposed for insurance prior to issuing your coverage. Some data will be obtained from you and some from other sources. That data and any data that is collected at a later date, may in some cases be disclosed to third parties without your specific consent subject to the Company’s privacy policies. You have the right of access and correction to data received about you. But, data about a claim or a civil or criminal proceeding is excepted. Details on these procedures will be furnished on request.

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

GUARANTEE TRUST LIFE INSURANCE COMPANY

Consent for Use of Electronic Records and Electronic Signatures

PLEASE PRINT AND SAVE A COPY OF THIS DOCUMENT FOR YOUR RECORDS

In connection with your application for, or administration of, insurance underwritten by Guarantee Trust Life Insurance Company ("GTL"), you are consenting to the use of Electronic Signatures and Electronic Records. As part of your consent to the use of Electronic Signatures and Electronic Records you acknowledge that you: (1) understand the terms and conditions of receiving insurance documents, disclosures and other communications electronically; (2) have the necessary hardware and software that allow you to receive and view Electronic Records; (3) have a valid active email account*; and (4) are responsible for accessing, opening, and reading communication GTL sends or makes available to you in electronic format. GTL will consider electronic communication to be received by you upon successful delivery to the designated email address you provide. You also acknowledge that your Electronic Signature is legally binding and enforceable and is the legal equivalent of your handwritten signature.

*An active email address is not required for viewing and / or downloading a copy of your insurance coverage from GTL's secure website.

GTL is required by law to provide you with the following information relative to (i) electronic delivery of disclosures, notices and other electronic communications (collectively, "Electronic Records") and (ii) Electronic Signature.

Types of Electronic Records Covered by This Consent

Unless you request otherwise, documents that form our insurance relationship will be provided to you electronically. Electronic Records include, but are not limited to:

- Application(s) and related forms
- Policy or certificate insurance fulfillment documents
- Disclosures and notices, where required by state and / or federal law
- Customer service forms and claim forms
- Responses to customer service or claim-related communications initiated by GTL or you

Your consent does not apply to policy lapse or termination notices.

What You Need in Order to Receive or View Electronic Records

In order to access and view communications and documents GTL makes available to you electronically, you must:

- Have access to the internet and be able to view, save and print Portable Document Files (PDF) using software such as Adobe Acrobat Reader. Adobe Acrobat Reader can be downloaded for free at http://get.adobe.com/reader/
- Maintain a valid active email address. It is your responsibility to provide GTL with your complete and accurate email address, as well as provide prompt notification of any change to it. To ensure Electronic Records are not blocked in email or spam filters, please add GTL's domain, gtlic.com, to your safe sender list.

Your Right to Request Paper Copies

To ensure you have them when you need them, it's recommend that you print copies of the Electronic Records GTL makes available to you, or save them to your personal computer or other electronic device. However, you may request a paper copy of any Electronic Record listed above free of charge. Except where prohibited by law, GTL may charge a nominal fee for additional copies requested after the first. Your request can be sent in writing, by phone, or email as indicated in the Company Contact Information, shown below.

Right to Send Paper

GTL reserves the right to provide paper copies in lieu of Electronic Records. This would be done in the event of, but not limited to, a system outage, if fraud is suspected, or where the designated email address you have provided does not accept emails from GTL.

Changes to the Terms and Conditions of Electronic Communication

GTL reserves the right to modify the terms and conditions stated herein. GTL will provide you with notice electronically of such change, its effective date, and your choices under the new terms and conditions.

Withdrawal of Consent

You may elect to withdraw your consent for Electronic Records at any time by contacting us in writing, by phone, or through the Policyholder - Customer Service link on GTL's website. Please see the 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 *Customer Service* tab at the top of the screen and choose *Customer Support*. In the Customer Support site there is a *Contact Us* option you may use to email us your request.

INSURANCE PRODUCER COMPENSATION DISCLOSURE

*(**Required with health insurance sales in Colorado)*

State law requires that any agent selling certain forms of health insurance products in your state disclose that the agent will receive compensation (commission) from the sale of that product.

** Excludes Long Term Care, Disability Income, and Credit Insurance.

This disclosure is to notify you that your agent _____ will receive a standard compensation of ____% 1st year commission on health insurance premium for the sale of this product or a service fee of $_____. If there is any change to your agent's commission percentage or service fee from the time of this disclosure until your policy is delivered, the change will be disclosed to you.

Type of Health Insurance Product:_____

Your agent's commission or service fee will be paid either:

- Directly from the Carrier: _____; Or
- From the agent's Managing Agency: _____ ; Or
- From a Third Party Administrator or Management _____.

I certify that the information referenced above was provided to the applicant at the time of solicitation.

Agent's Signature: _____ Date: ___/___/_____

Delivery Method: _____ In person _____ USPS Mail _____ Email