GTL | GUARANTEE TRUST LIFE

ADVANTAGE PLUS® ELITE

Hospital Indemnity Insurance

Agent Name:

Phone:

APPLICANT INFORMATION PACKET

WEST VIRGINIA

REQUIRED TO LEAVE WITH APPLICANT

INCLUDES:

- OCG2150-WV – Advantage Plus Elite Hospital Indemnity Outline of Coverage
- MEDDUP-5 – Medicare Duplication Notice
- HIPAA- Notice of Privacy Practices
- PRE-NOTICE TO PROPOSED INSURED
- E-CONSENT– Electronic Delivery and Communications Disclosure

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

(Rev. 10/23) 15A0384

GUARANTEE TRUST LIFE INSURANCE COMPANY
A Mutual Company
1275 Milwaukee Avenue, Glenview, Illinois 60025
(800) 338-7452

Advantage Plus
LIMITED BENEFIT POLICY
Providing Indemnity Benefits for Hospital Confinement and Optional Indemnity Benefit Riders

OUTLINE OF COVERAGE
For Policy Form G2150
Optional Rider Forms: RG21ASB, RG21CA, RG15CLS, RG15CLSR, RG15DV, RG21LSH, RG21OPS, RG21OPT, RG21SNF, RG21SNF-EP

KEEP THIS OUTLINE FOR YOUR RECORDS

THIS IS NOT QUALIFYING HEALTH COVERAGE (''MINIMUM ESSENTIAL COVERAGE'') THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DON'T HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

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!**

This is a supplement to health insurance and is not a substitute for major medical coverage. It does not qualify as minimum essential health coverage under the Federal Affordable Care Act.

LIMITED BENEFIT COVERAGE –The 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 Injury or Sickness. 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 pay benefits for Hospital Confinements, Mental Health Benefits, Emergency Room/Urgent Care Benefits, and Short-Duration Hospital Stay Benefits that are Medically Necessary.

BENEFIT A: HOSPITAL CONFINEMENT BENEFIT (INJURY OR SICKNESS)
We will pay the selected Hospital Confinement Indemnity Benefit Amount for each Day You are Hospital Confined due to Injury or Sickness. Benefits are subject to the selected Maximum Benefit Period for any One Period of Confinement.

Hospital Confinement Benefit Amount selected: $_____ per Day

Maximum Benefit Period - available options: ☐ 1 day ☐ 3 days ☐ 4 days ☐ 5 days ☐ 6 days ☐ 7 days ☐ 8 days ☐9 days ☐ 10 days ☐ 15 days

BENEFIT B: MENTAL HEALTH BENEFIT
We will pay a Mental Health Benefit of $175 for each Day you are Hospital Confined due to a Mental or Nervous Disorder. This benefit is subject to a maximum of seven (7) Days per Calendar Year.

We will not pay benefits under both Benefit A and Benefit B above for the same Day of Hospital Confinement.

BENEFIT C: EMERGENCY ROOM/URGENT CARE BENEFIT (INJURY ONLY)
We will pay an Emergency Room Benefit of $150 for services received in a Hospital Emergency Room or Hospital affiliated emergency care facility for loss due to Injury. This benefit is payable once per any sixty (60) Days.

BENEFIT D: SHORT-DURATION HOSPITAL STAY BENEFIT: We will pay the Short-Duration Hospital Stay Indemnity Benefit Amount per Short-Duration Hospital Stay if You are hospitalized for at least six (6) hours. This benefit is payable once every sixty (60) calendar Days. The Short-Duration Hospital Stay Benefit will not be payable for any Day a Hospital Confinement Indemnity Benefit is payable.

LIMITATIONS AND EXCLUSIONS:
Pre-existing Condition: The Policy has a Pre-Existing Condition limitation. We will not pay benefits for a Pre-Existing Condition unless the loss begins more than six (6) months after Your Effective Date of coverage.

GENERAL EXCLUSIONS
We will not pay benefits under the Policy for a Loss related to any of the following:

1. Treatment, devices, procedures, services or supplies which:
   - Are not deemed to be Medically Necessary by Your Doctor;
   - Are determined by Us to be Experimental in nature;
   - Are received without charge or legal obligation to pay;
   - Would not routinely be paid in the absence of insurance;
   - Are received from an Immediate Family member;
   - Are received outside the United States.
2. Injury or Sickness caused, or aggravated, by intentionally self-inflicted injuries, suicide, or attempted suicide while sane or insane.
3. Injury or Sickness incurred as a result of war, or any action of war (declared or undeclared) or active service in the armed forces of any country.
4. Injury or Sickness incurred as a result of an Insured participating in, committing, or attempting to commit an assault or felony or participating in a riot or civil commotion.
5. Injury or Sickness arising out of or in the course of employment and which is payable or covered under any workers' compensation or occupational disease act or law.
6. Cosmetic or elective surgery other than:
   a. Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other Sickness or Injury of the involved part; or
   b. Reconstructive surgery because of a congenital Sickness or anomaly.
7. Any Injury or Sickness caused by the Insured's participation in any activity or event, including the operation of a vehicle, while under the influence of a controlled substance (unless administered by a Doctor or taken according to the Doctor's instructions) or while intoxicated (intoxicated means that condition as defined by the law of the jurisdiction in which the Injury or Sickness occurred).
8. Injury or Sickness resulting in confinement in, or treatment provided by, a Hospital due to alcohol, or Your voluntary use of any drug, narcotic or other controlled substance, unless taken as prescribed by a Doctor.
9. Losses incurred prior to the Policy Effective Date, or on or subsequent to its termination or expiration date.

OPTIONAL BENEFIT RIDERS: (Available for an additional premium)

Skilled Nursing Facility Benefit Rider RG21SNF-EP *(Pays from Days twenty-one (21) to one-hundred (100))*

We will pay the Skilled Nursing Benefit Amount for each Day you are confined in a Skilled Nursing Facility provided that:

1. You have first been Hospital Confined for three (3) or more consecutive Days;
2. The Skilled Nursing Facility confinement begins within thirty (30) Days after such Hospital Confinement;
3. Your Doctor certifies to the need for the Skilled Nursing Facility confinement; and
4. The Skilled Nursing Facility confinement is for the same covered Injury or Sickness as the Hospital Confinement for which We paid benefits.

The Skilled Nursing Facility Benefit is subject to a twenty (20)-Day Elimination Period and a Maximum Benefit Period of eighty (80) Days per Any One (1) Period of Confinement.

Skilled Nursing Facility Benefit Amount Selected: $_____

Skilled Nursing Facility Benefit Rider RG21SNF (*Pays from Days one (1) to fifty (50))*

We will pay the Skilled Nursing Benefit Amount for each Day you are confined in a Skilled Nursing Facility provided that:

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

The Skilled Nursing Facility Benefit may be subject to an Elimination Period. The Elimination Period, if any, will be shown in the Policy Schedule. The Skilled Nursing Facility Benefit is subject to a Maximum Benefit Period of fifty (50) Day(s) per Any One (1) Period of Confinement.

Skilled Nursing Facility Benefit Amount Selected: $_____

Lump Sum Hospital Benefit Rider RG21LSH

We will pay the selected Lump Sum Hospital Benefit Amount when You are Hospital Confined due to a covered Injury or Sickness. It is payable once per any One (1) Period of Confinement.

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

Ambulance Service Benefit Rider RG21ASB

We will pay the Ambulance Service Benefit Amount when Ground Ambulance or Air Ambulance, as defined in the Policy, is used to transport You to or from a Hospital. This Benefit is payable no more than once per Day (twenty-four (24)-hour period) regardless of the number of ambulance transports. Benefit payment is subject to a Calendar Year maximum and a Lifetime Maximum. The Ambulance service must be Medically Necessary and due to a covered Injury or Sickness. In the event both Air Ambulance and Ground Ambulance are used to transport You to a Hospital within a twenty-four (24) hour period, it is considered one (1) transport and only one (1) Ambulance Service Benefit is payable.

Transports per Calendar year: 4 Lifetime Maximum Transports: 12

Ambulance Service Benefit: ☐$50 ☐$100 ☐$150 ☐$200 ☐$250 ☐$300 ☐$350 ☐$400

Outpatient Rehabilitation Therapy Benefit Rider RG21OPT

We will pay the daily Outpatient Rehabilitation Indemnity Benefit, as defined in the Policy, for each Day You receive one (1) of the therapies defined in the Rider on an Outpatient basis. Such therapy must be prescribed a Doctor for Medically Necessary treatment of a covered Sickness or covered Injury. No more than one (1) benefit will be paid per Day under the Rider. This benefit is limited to the maximum daily benefit and the maximum number of Days per Calendar Year shown on the Policy Schedule.

LIMITATIONS AND EXCLUSIONS

In addition to the General Exclusions in the Policy, We will not provide benefits for treatment, services, or supplies which are not prescribed by a Healthcare Professional as Medically Necessary to treat Sickness or Injury.

Benefits for Chiropractic Therapy are payable only for an Injury due to an Accident.

Daily Benefit: $50 per Day
Maximum Benefit Period Selected for Physical / Occupational / Speech Therapies: ☐15 ☐30 Days per Calendar Year
Maximum Benefit Period for Chiropractic Therapy: 5 Days per Calendar Year (Payable for Injury due to an Accident.)

Outpatient Surgical Benefit Rider RG21OPS

We will pay the selected Surgical Benefit Amount for a Surgery performed by a Doctor when such Surgery is performed in an Ambulatory Surgical Center or Outpatient Facility of a Hospital. This benefit is payable up to two (2) occurrences per Calendar Year not to exceed the Maximum Outpatient Surgical Benefit Amount.

The following exclusions are in addition to the exclusions contained in the Policy to which this Rider is attached. We will not pay benefits for Loss due to:

1. Surgery not performed in an Ambulatory Surgical Center or Outpatient Facility; Surgery performed in a Doctor's office; or Surgery performed when Hospital Confined;
2. Surgery for corns, calluses and bunions; deviated nasal septum, including sub mucous resection; and/or other surgical corrections thereof, unless due to Injury occurring while coverage is in force;
3. Surgery for the removal of breast implants, except where the removal of the breast implants was caused by Medically Necessary treatment of a covered Injury or Sickness and the initial surgery, resulting in the implantation of the breast implants, was due solely to reconstruction caused by an Injury or Sickness;
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. Endoscopic procedure without tissue biopsy or repair performed;
8. Needle aspiration;
9. Elective Surgery or cosmetic surgery; or
10. Surgery for refractive anomalies, including, but not limited to, laser assisted in situ keratomileusis ("LASIK") eye surgery.

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

Dental and Vision Benefit Rider RG15DV

We will pay benefits for: (a) non-preventative dental services; and (b) preventative dental and vision services. Preventative dental services are covered with a Calendar Year maximum benefit of $75. An annual eye examination or eye refraction is covered with a Calendar Year maximum benefit of $50. Coverage for prescription eyeglasses is provided up to an annual maximum of $200 per Calendar Year.

Dental and Visions benefits are subject to the:

- Annual Rider Deductible: $100
- Insured Percent of covered expenses; and
- Selected Calendar Year Rider Maximum Amount.

The Rider Deductible Amount and Insured Percent of covered expenses do not apply to preventative dental or eye examination / eye refraction services.

Rider Maximum Amount Selected: ☐ $400 ☐ $800 ☐ $1,200

THIS RIDER PROVIDES LIMITED BENEFITS DURING THE FIRST TWELVE (12) MONTHS AFTER THE RIDER EFFECTIVE DATE. PLEASE READ THE RIDER CAREFULLY.

Dental and Vision Rider Exclusions

Benefits will not be paid for dental expenses arising from or in connection with:

- A service not furnished by a Dentist, except:
  - That performed by a Dental Hygienist under the supervision of a Dentist; and
  - X-rays ordered by a Dentist.
- Treatment, services or supplies which are:
  - Not Necessary Dental Treatment, except as provided herein;
  - Experimental/Investigational in nature;
  - Conditions covered by Workers Compensation Services.
- Treatment by a Family Member;
- Services or supplies for which there would be no charge in the absence of insurance;

- A service furnished to You for:
  - Cosmetic purposes, unless needed as a result of Injury. Facing on crowns, on pontics, posterior to the second bicuspid shall always be considered cosmetic; or
  - Dental care of congenital or developmental malformation (unless benefits for orthodontic services are specifically provided in the Schedule.)
- Implants; replacement of lost or stolen appliances, replacement of orthodontic retainers, athletic mouth guards, precision or semi-precision attachments; denture duplication; or sealants;
- Oral hygiene instructions; plaque control; acid etch; or prescription for take-home fluoride;
- Over dentures and associated procedures;
- Services not completed by the end of the month in which insurance terminates; or
- Orthodontic related expense, unless specifically provided.

Benefits will not be paid for vision expenses arising from or in connection with:
- Treatment, services or supplies which:
  - Are Experimental/Investigational in nature;
  - Are received without charge or legal obligation to pay; or
  - Treatment by any Family Member.
- Conditions covered by Worker's Compensation Services;
- Services and supplies in connection with special procedures such as: orthoptics or vision training and subnormal vision aids;
- Non-prescription (plano) eyewear;
- Medical or surgical treatments of the eyes, unless to correct refraction of the eyes; or
- Eye examinations required by an employer as a condition of employment.

First Diagnosis Cancer Lump Sum Benefit Rider (Rider Form RG15CLS)
or First Diagnosis Cancer Lump Sum with Recurrence Benefit Rider (Rider Form RG15CLSR)

We will pay a lump sum benefit, as shown below, if Cancer is diagnosed after the Effective Date of coverage, subject to any Waiting Period.

First Diagnosis Benefit: The First Diagnosis Cancer Lump Sum benefit is payable for an internal Cancer and is limited to one (1) lump sum benefit amount during Your lifetime.

Cancer in Situ Benefit: The Cancer in Situ Benefit Amount is payable at 25% of the First Diagnosis Cancer Lump Sum Benefit. The Cancer in Situ Benefit is limited to one (1) lump sum payment during Your lifetime.

Skin Cancer Benefit**:** A Skin Cancer Benefit of $500 is payable for a diagnosis of squamous cell or basal cell skin carcinoma. The Skin Cancer Benefit is limited to one (1) payment per Calendar Year. The maximum we will pay is three (3) Skin Cancer Benefits during Your lifetime.

Recurrence Benefit: **This benefit is only available with Rider Form RG15CLSR.** A Recurrence Benefit is payable for a previously diagnosed or newly diagnosed Cancer. Benefit payment is subject to having been in a period of remission for at least one (1) full year from a previously diagnosed Cancer for which we have previously paid benefits under the Policy. The Recurrence Benefit is a percentage (10% to 100%, depending upon the number of years elapsed) of the First Diagnosis Cancer Lump Sum Benefit amount. Benefits payable under the Recurrence Benefit provision are not subject to a lifetime maximum.

Benefits for the recurrence of a previously diagnosed Cancer are subject to documented medical evidence that supports a Cancer's period of remission.

Cancer, Cancer in Situ or Skin Cancer will not be a covered condition when advice or treatment is received within the Waiting Period, if any, or prior to the Effective Date, and such advice or treatment results in the First Diagnosis of Cancer, Cancer in Situ, or Skin Cancer. If tissue is extracted during the Waiting Period, if any, or prior to the Effective Date, and results in a First Diagnosis of Cancer, Cancer in Situ, or Skin Cancer, this will not be a covered condition. If Cancer, Cancer In Situ, or Skin Cancer is diagnosed and/or treated within the Waiting Period, or if medical advice is given within the Waiting Period which leads to the subsequent First Diagnosis of Cancer, Cancer In Situ, or Skin Cancer after the Waiting Period, You have the option to cancel the Rider and receive a refund of all premiums paid on this Rider.

☐ Cancer Lump Sum Benefit: ☐$2,500 ☐$5,000 ☐$7,500 ☐$10,000 ☐$15,000 ☐$20,000

☐ Cancer Lump Sum Benefit with Recurrence: ☐$2,500 ☐$5,000 ☐$7,500 ☐$10,000 ☐$15,000 ☐$20,000

CRITICAL ACCIDENT BENEFIT RIDER – FORM RG21CA

Maximum Benefit Amount per Accident: ☐$5,000 ☐$10,000

Lifetime Maximum Benefit Amount: Same as selected Maximum Amount per Accident

This Rider pays limited benefits for the following types of Injuries: hip and knee dislocation; fractures; and knee ligament and meniscus tears. To be eligible for benefits, you must receive Medically Necessary services in an Emergency Room or Urgent Care Facility to treat such Injuries within forty-eight (48) hours of a covered Accident. Benefit payment is subject to a thirty (30) Day Waiting Period. Benefits are paid as a percentage of the Maximum Benefit Amount per Accident:

Covered Injury	Percentage of Maximum Benefit Amount Per Accident That Will be Payable
Dislocation, hip	20%
Dislocation, knee	10%
Fracture, hip or skull	25%
Fracture, all other	5%
Tear, knee ligament or meniscus	10%

If more than one (1) Fracture, Dislocation and / or Knee Ligament / Meniscus Tear is sustained as a result of a covered Injury, only one (1) benefit is payable. The benefit payable will be that of the highest benefit amount associated with the sustained Fracture, Dislocation, or Knee Ligament/Meniscus Tear.

A Loss of Life Benefit is payable in the event of death within 90 Days as a result of Injuries sustained in a covered Accident. The Loss of Life Benefit is equal to the Maximum Benefit Amount Per Accident.

CRITICAL ACCIDENT BENEFIT RIDER EXCLUSIONS: This rider does not provide benefits for:

1. Treatment, devices, procedures, services or supplies which:
   a. Are not prescribed by a Doctor to treat an Injury; or
   b. Are provided outside of an Emergency Room or Urgent Care Facility.
2. Fracture of fingers, toes, ribs or coccyx.
3. Intentionally self-inflicted Injury, suicide, attempted suicide, or any Injury sustained while violating or attempting to violate any duly enacted law.
4. Injury received while traveling or operating, learning to operate, serving as a crewmember on, or jumping or falling from any aircraft including those, which are not motor-driven.
5. Cosmetic surgery, except for reconstructive surgery on an injured part of the body.
6. Dental treatment.
7. Treatment of Sickness, disease or degenerative process, including degenerative joint disease and/or non-traumatic arthritis. We also will not pay benefits for any related medical treatments or diagnostic procedures.
8. Treatment of vegetation or ptomaine poisoning or bacterial infections, except pyogenic infections due to accidental open cuts; or accidental ingestion of contaminated substances.
9. Injury resulting from testing cars/trucks on any racetrack or speedway.
10. Injury resulting from participation in intercollegiate sports.
11. Injury sustained while taking part in any of the following activities: as a rider in or driving in competitive motor sport, water sport races, stunt show or speed test, or while testing any vehicle on any racecourse or speedway; spelunking (exploring caves); mountaineering, scaling up or down cliffs or mountain walls; practice for or participation in a rodeo; flying in an ultralight, hang gliding, parachuting, parasailing, parakiting, bungee cord jumping.
12. Participating in any sporting event for pay or prize money.
13. Injuries incurred and resulting from all occupations, including, but not limited to, circus workers, commercial fishermen, crop dusters, farm laborers, firefighters, lumberjacks, oil field workers, police, quarry workers, rodeo riders, security guards, underground miners, or window washers.
14. Injuries incurred more than forty (40) miles outside the territorial limits of the United States or Canada, unless such loss is incurred while You are on a trip of not more than sixty (60) Days.

GUARANTEED RENEWABLE FOR LIFE You may keep the Policy, and any selected Riders, in force during Your 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 Policy's thirty-one (31) Day grace period. We cannot cancel or refuse to renew the 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 the Policy/Riders by giving you at least thirty-one (31) Days advance 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 Confinement Policy:	**$**_____
☐ **Skilled Nursing Facility Benefit Rider** *(Days 21-100*)**:**	**$**_____
☐ **Skilled Nursing Facility Benefit Rider** *(Days 1 – 50)***:**	**$**_____
☐ **Lump Sum Hospital Benefit Rider:**	**$**_____
☐ **Ambulance Service Benefit Rider:**	**$**_____
☐ **Outpatient Surgical Benefit Rider:**	**$**_____
☐ **Outpatient Rehabilitation Therapy Rider**	**$**_____
☐ **Dental and Vision Benefit Rider:**	**$**_____
☐ **Cancer Lump Sum Benefit Rider:**	**$**_____
☐ **Cancer Lump Sum with Recurrence Benefit Rider:**	**$**_____
☐ **Critical Accident Rider:**	**$**_____
Policy/Application Fee (if applicable)	**$**_____
TOTAL PREMIUM:	**$**_____

IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

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.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

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
- outpatient prescription drugs if you are enrolled in Medicare Part D
- hospice
- other approved items and services

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

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you the different ways in which Guarantee Trust Life Insurance Company ("GTL") may use and disclose your protected health information.

Among other things, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to:

- Maintain the privacy of your protected health information.
- Provide notice of GTL's legal duties and privacy practices with respect to your protected health information.
- Comply with the terms of the Notice currently in effect; and
- Provide you with this Notice.

You have a right to a paper copy of this Notice which will be provided to you upon request, even if this Notice was provided to you electronically.

Protected health information is information about you that is either held or transmitted by GTL, including demographic information, that identifies you (or can reasonably be used to identify you), and that relates to (i) your past, present or future physical or mental health or condition, (ii) the provision of health care to you, or (iii) the past, present or future payment for the provision of health care to you.

GTL understands that your protected health information is personal. We protect the privacy of that information in accordance with all federal and state privacy laws. If a use or disclosure of protected health information described within this Notice, which is required by federal law, is prohibited or materially restricted by state law, GTL will abide by the more stringent law.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITH YOUR WRITTEN AUTHORIZATION

GTL will not use or disclose your protected health information without your written authorization unless the use or disclosure is described within this Notice.

If you have given us written authorization to use or disclose your protected health information, you have the right to revoke that authorization, at any time, except to the extent that: (1) we have already acted in reliance on the authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides us with the right to contest a claim under the policy or the policy itself. Your written request to revoke an authorization should be directed to the address listed in the "Contact Information" section below.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

For Payment

We may request, use and disclose your protected health information, as needed, to determine or fulfill our responsibility for coverage and reimbursement for the provision of benefits under your health plan. This may include, but is not limited to:

- determinations of eligibility of coverage (including coordination of benefits with other insurers or the determination of cost sharing amounts) and adjudication or subrogation of health benefit claims;
- risk adjusting based on enrollee health status and demographic characteristics;
- billing, claims management, collection activities, obtaining payment under a contract for reinsurance;
- review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;
- utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services;

- disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: name and address; date of birth; social security number; payment history; policy/account number; and name and address of the health care provider and /or health plan.

For example, if your coverage has a coordination of benefits or other type of cost sharing provision, we may request and disclose protected health information about you to the other health plan carrier to determine the benefits due under the terms of your health plan with us. We may also contact your provider regarding your medical treatments and request details to determine if your coverage will pay for the treatments.

For Health Care Operations

We may use and disclose protected health information about you to support our business operations or the business operations of another insurer. These uses and disclosures are necessary to run the company and make sure all of our policyholders receive the services and benefits provided by their health plan coverage. These activities include, but are not limited to:

- underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, however, we are prohibited from using or disclosing genetic information about you for underwriting purposes;
- ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services, and auditing functions, including fraud investigations;
- business planning and development, such as conducting cost-management studies and analyses related to managing and operating the company, including development or improvement of methods of payment or coverage policies; and
- business management and general administrative activities of the company, including, but not limited to:
  - customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
  - resolution of internal grievances; and
  - the offer of an enhancement or upgrade to your existing coverage.

To Individuals Involved in Your Care

We may use and disclose your protected health information with your family, friends, personal representative or other individual you identify who are involved in your care or payment of a claim, unless you object. In addition, GTL may use and disclose your protected heath information to persons requesting such information if we can reasonably infer from the circumstances that you would not object to the disclosure. If you are not available to give your consent to a disclosure, or in an emergency, we may disclose your protected health information that is directly relevant to such person's involvement in your care or payment for such care.

To Our Business Associates

We may also share your protected health information to an affiliate or business associate outside of GTL if they need protected health information in order to provide services to us (e.g., billing, claim adjudication and underwriting services.) Whenever an arrangement between GTL and a business associate involves the use or disclosure of your protected health information we will have a written contract that sets forth the terms regarding the use and disclosure of your protected health information and will require them to follow the HIPAA rules relating to the protection of protected health information.

For Other Uses and Disclosures

In addition to the above, we are permitted or required by law to use or disclose your protected health information, without your permission, for the following:

- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order. We may disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement:** We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process. We may also disclose your protected health information if we suspect child abuse or neglect; we may also disclose your protected health information if we believe you to be a victim of abuse, neglect, or domestic violence.

- **Health Oversight Activities:** We may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

You have the following rights with respect to the protected health information we maintain about you.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to us or to the business associate who maintains the medical information. If we would prefer to send you a summary or explanation of your medical information rather than the actual records, we may do so only with your consent and your agreement in advance to the fees imposed, if any. You may request your records be in paper or electronic format. We may charge a fee for the costs of copying, mailing or other supplies associated with mailing or copying your protected health information. We may deny your request in whole or in part to inspect and copy records in certain circumstances. If you are denied access to medical information, we will provide a written notice explaining the basis for the denial. You may also request that the denial be reviewed. Such request for review will either be approved or denied based on the grounds for denial. If the initial denial is reviewable, the person conducting the review will not be the same person who denied your original request. We will comply with the determination of the representative performing the review.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request and we retain the right to terminate an agreed to restriction. Such termination is only effective with respect to protected health information created or received after GTL has informed the individual of its termination of the restriction. Additionally requesting certain limitations may affect payment of benefits under your health plan. To request restrictions, you must make your request in writing to our Customer Service Department. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

You have the right to request and receive confidential communications. We will accommodate reasonable requests to send your protected health information to you at a different address, or other method of contact. We will not request an explanation from you as to the basis for the request. For example, you can ask that we only contact you at work or by mail. Requests for confidential communications must be made in writing, signed by you and sent to GTL. Your request must specify how or where you wish to be contacted.

You have the right to request an amendment of your protected health information. You may request an amendment of your health information contained in a designated record set for as long as the information is kept by GTL or any of our business associates. To request an amendment, you must send us your request in writing to the address included in the "Contact Information" section below, giving details of your request and why you are making it. If we deny your request for amendment in whole or in part, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement. We will provide you with a copy of any such rebuttal. In certain cases, we may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the designated record set kept by us; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.

You have the right to receive an accounting of certain disclosures. You have the right to request an accounting of most disclosures of protected health information made by us during the six years prior to the date the accounting is requested, subject to certain exceptions. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a cost-based reasonable fee.

You have the right to be notified following a breach of unsecured protected health information. You have the right to and will receive a notification of a breach of your unsecured protected health from GTL, or one of its business associates.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint in writing to us at the address shown below in the "Contact Information" section. You may also file a complaint in writing with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

THIS NOTICE IS SUBJECT TO CHANGE
We reserve the right to change the terms of this Notice and our privacy policies at any time. If we do, the new terms will be effective for all protected health information maintained by us, including protected health information received by GTL before the effective date of the new terms. If we do revise our privacy notice, a copy of the new notice will be posted on our web site at www.gtlic.com and/or sent to you if the changes are material.

EFFECTIVE DATE
This Notice is effective September 23, 2013.

CONTACT INFORMATION
If you have questions regarding this Notice or require further information, you may contact our Customer Service Department at 1-800-338-7452. Any written complaints should be directed to Guarantee Trust Life Insurance Company, Attention: Privacy Office, 1275 Milwaukee Avenue, Glenview, Illinois 60025.

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 recommended 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.