SELECT BENEFIT
SERVICES ASSOCIATION

MEMBERSHIP ENROLLMENT FORM

Select Benefit Services Association (SBSA) is a membership organization committed to providing members high quality, innovative and money saving benefits and services. Membership privileges include the right to participate in all programs offered or sponsored by SBSA.

I hereby request enrollment in Select Benefit Services Association.
I understand that dues will be collected with my insurance premiums.
I further understand that membership in SBSA is required in order to apply for Group Hospital Confinement Indemnity Insurance.

I Apply For:

☐ Individual Membership - $3.50 per month

☐ Individual and Spousal Membership - $7.00 per month

Applicant Name (Printed)

Spouse Name (Printed)

Applicant Signature

Spouse Signature

Application For: Indemnity Plus
Group Hospital Confinement Indemnity Insurance

Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue Glenview, IL 60025 (800) 338-7452

INDEMNITY PLUS

Application for: ☐ New Coverage ☐ Increase of Benefits

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

NOTE: Enrollment in Association is required in order to apply for coverage. See membership enrollment form.

SEND CERTIFICATE DOCUMENTS TO: ☐ **AGENT** ☐ **INSURED**

Applicant 1

Last Name _____ First Name_____ M.I. ____

Social Security Number_____ /_____ /_____ Age _____ Date of Birth _____ /_____ /_____ ☐ Male ☐ Female

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

_____
Full Legal Name of Beneficiary

Applicant 2

Last Name _____ First Name_____ M.I. ____

Social Security Number_____ /_____ /_____ Age _____ Date of Birth _____ /_____ /_____ ☐ Male ☐ Female

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

_____
Full Legal Name of Beneficiary

Address

Street Address _____

City _____ State: _____ Zip Code: _____

_____ _____
Applicant 1 E-mail Address Applicant 2 E-mail Address

Applicant 1 Phone Number _____ Applicant 2 Phone Number _____

Pre-Qualification, Medical Information & Exclusions

IF YOU ARE BETWEEN THE AGES OF 64 1/2 and 65 1/2, AS OF THE DATE OF THIS APPLICATION, SKIP QUESTIONS 1 THROUGH 5 FOR INDEMNITY PLUS COVERAGE.
If any answer to questions 1 through 5 is Yes, you are not eligible for coverage.
NOTE: Pre-existing Condition limitations apply without regard to answering questions 1 through 5.

INDEMNITY PLUS	Applicant 1	Applicant 2
1. In the past 6 months have you been confined as an inpatient to a hospital, nursing home or received home health care?	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past 12 months have you had a heart attack, Atrial Fibrillation, congestive heart failure, stroke, Transient Ischemic Attack (TIA), heart surgery/bypass, malignant melanoma or cancer (other than skin cancer)?	☐ Yes ☐ No	☐ Yes ☐ No
3. In the past 12 months have you had, been diagnosed with or been treated for 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?	☐ Yes ☐ No	☐ Yes ☐ No
4. In the past 12 months have you been advised to have surgery which will require an inpatient stay but have not yet done so?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you ever been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?	☐ Yes ☐ No	☐ Yes ☐ No

LUMP SUM CANCER (To be completed if applying for Lump Sum Cancer Rider)	Applicant 1	Applicant 2
1. In the past 5 years has any person to be insured had, been diagnosed as having, received medication for or been treated by a medical professional for:		
a. Chronic Obstructive Pulmonary/Lung Disease (COPD/COLD), emphysema or chronic bronchitis requiring the use of two or more medications? ***If Yes, the applicant does not qualify for the rider.***	☐ Yes ☐ No	☐ Yes ☐ No
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, a pre-malignant condition or a condition with malignant potential? ***If Yes, the applicant does not qualify for the rider.***	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past 5 years, has any person to be insured been tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection? ***If Yes, the applicant does not qualify for the rider.***	☐ Yes ☐ No	☐ Yes ☐ No
3. For any of the conditions which benefits are being applied for, within the past 24 months, has any person to be insured had:		
a. An abnormal test result or a medical condition which requires further diagnostic evaluation or testing but has not yet been completed; or had a symptom or abnormality that would have caused a person to seek medical attention or advice for but has not yet done so; or is awaiting test results? ***If Yes, the applicant does not qualify for the rider.***	☐ Yes ☐ No	☐ Yes ☐ No

CRITICAL ACCIDENT BENEFIT RIDER (To be completed if applying for Critical Accident Benefit Rider)	Applicant 1	Applicant 2
1. In the past 3 years has any person participated or intend to participate in flying as a private pilot or crew member, skydiving, parachuting, hang gliding, organized racing (water, land or air), testing cars on a racetrack or speedway, mountain climbing, spelunking, rodeo practice or participation, bungee jumping, in collegiate sports, or participated in any sporting event for pay or prize money?	☐ Yes ☐ No	☐ Yes ☐ No
2. In the past 12 months has any person been prescribed medication or had surgery or recommended surgery, or undergone therapy for a back, neck or joint disorder?	☐ Yes ☐ No	☐ Yes ☐ No
If YES for 1 or 2, the applicant is not eligible for Critical Accident Benefit Rider.		

INDEMNITY PLUS COVERAGE SELECTION & PREMIUMS

	Applicant 1	Applicant 2
➤ Daily Hospital Amount for the Initial Benefit Period Choose an amount from $100 to $2,500 (in $10 increments) *The Short Duration Hospital Stay Benefit is included for the 1, 3 and 6 initial day benefit periods only.* Daily Benefit for a 1 Day plan is $1,000 to $2,500 Daily Benefit for a 3 Day plan is $350 to $750 Daily Benefit for a 6 Day plan is $250 to $750 Daily Benefit for a 10 Day plan is $100 to $750 Daily Benefit Amount for the Remainder of the 31-Day Maximum Benefit Period	$_____ Benefit Amount Per Day $15 Per Day	$_____ Benefit Amount Per Day $15 Per Day
➤ Select number of Initial Benefit Period Days	☐ 1 ☐ 3 ☐ 6 ☐ 10	☐ 1 ☐ 3 ☐ 6 ☐ 10

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*
➤ Short Duration Hospital Stay Benefit Rider *(Available for 10-day benefit period.)*	☐	☐
➤ Skilled Nursing Facility Benefit Rider *(choose one)* Option 1: Benefits payable from Day 1 through 50 **OR** Option 2: Benefits payable from Day 21 through 100	☐ $100 ☐ $150 ☐ $200 **OR** ☐ $120	☐ $100 ☐ $150 ☐ $200 **OR** ☐ $120
➤ Lump Sum Cancer Benefit Rider (Includes $500 Basal Cell/ Squamous Cell Skin Carcinoma benefit and 25% Cancer In-Situ Benefit)	☐ $2,500 ☐ $5,000 ☐ $6,700 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ With 100% Recurrence Benefit	☐ $2,500 ☐ $5,000 ☐ $6,700 ☐ $10,000 ☐ $15,000 ☐ $20,000 ☐ With 100% Recurrence Benefit
➤ Critical Accident Benefit Rider	☐ $5,000 ☐ $10,000	☐ $5,000 ☐ $10,000
➤ 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 Indemnity Plus:	$_____	$_____
Association Dues	$_____	$_____

Premium Payment Method: ☐ Draft (PAC) ☐ Direct Bill (Collect first premium payment for direct bill mode)

Premium Payment Mode: ☐ Annual ☐ Semi-Annual (.50) ☐ Quarterly (.25) ☐ Monthly (.08333) (PAC Only)

Requested Effective Date: _____/_____/_____

Requested Effective Date cannot be prior to the Application Date. If no Effective Date is requested, the coverage will be effective on the date approved by underwriting.

Requested Draft Date: _____/_____/_____

Premiums

Applicant 1 Total Premium: $_____

Applicant 2 Total Premium: $_____

Application Fee *(if Applicable)* $_____

Total Submitted Premium: $_____

Applicant(s) Coverage Information

	Applicant 1	Applicant 2
Will this coverage 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

Applicant 1:

_____

Company | Type of Insurance | Policy Number

Applicant 2:

_____

Company | Type of Insurance | Policy Number

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: ALL STATEMENTS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I (WE) UNDERSTAND THAT FRAUDULENT AND MATERIAL OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR RESCISSION, VOIDING, OR REFORMATION OF INSURANCE.

I (We) understand that any changes in my (our) health conditions, from the date of this application until insurance becomes effective, may result in the declination of my (our) coverage. No agent or other representative of GTL has required, permitted, or encouraged me (us) to answer any question inaccurately or has waived any conditions of this application. I (We) have received a copy of the Pre-Notice which describes how information is obtained and used by GTL.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION: I (We) authorize Guarantee Trust Life Insurance Company (herein referred to as the "Company,") insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and criminal or motor vehicle records needed to underwrite my (our) application for insurance. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes,) such information or records from any doctor, health professional, hospital, clinic, the Veterans Administration, insurance company, pharmacy benefit manager, pharmacy or pharmacy-related facility which has such information including any medical information provided to any affiliate insurance company on previous applications and medical information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from MIB, Inc. I (We) authorize the Company, or its reinsurers, to make a brief report of my (our) personal health information to MIB, Inc. This Authorization includes all information about drugs, alcoholism, and mental illness. I (We) understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. Although federal regulations require that the Company inform me (us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. I (We) agree that this Authorization will be valid for 24 months from the date signed, and know that I (we) or my (our) authorized representative may have a photocopy of it. In the event my (our) application is approved and coverage is issued, I (We) acknowledge this authorization may also be used to obtain information or records, as stated above, as necessary to process a claim that is submitted within the timeframe during which this authorization remains valid.

I (We) understand that I (we) have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I (We) understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or so long as GTL has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my (our) agent or to the attention of the Underwriting Manager.

I (We) understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by GTL in accordance with federal or state law. I (We) also understand that my (our) application for insurance can be declined if I (we) choose not to sign this Authorization.

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. I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it. I have advised the applicant not to withhold any information relative to this application and its questions. I have advised the applicant to review the application for completeness and accuracy and that no coverage is in effect until they are notified in writing by Guarantee Trust Life Insurance Company.

Florida Agent's Signature, if applicable	Secondary Florida Agent's Signature, if applicable
Florida Agent's Name (please print) Florida Agent License #	Florida Agent's Name (please print) Florida Agent License #
Agent's E-mail Address	Agent's E-mail Address

GAPPH4-18-FL

PRE-AUTHORIZED PREMIUM PAYMENT PLAN

Authorization to Honor Withdrawals to be drawn by Guarantee Trust Life Insurance Company.

To _____
Name of my Bank

_____
My Bank's Address City State Zip

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of Guarantee Trust Life Insurance Company, Glenview, Illinois provided there are sufficient funds in my account to pay the same upon presentation.

Account Number_____ Banking Routing Number _____

Account Type: ☐ Checking Account *(Attach a Voided "Sample" Check)*

☐ Savings Account *(Attach a Voided "Sample" Check if applicable or a Deposit Slip)*

Requested Draft Date _____/_____/_____

I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

_____ _____
Printed name of insured if different from premium payer Premium payer's signature, as it appears on bank records

Detach Here

Receipt

Date_____

Received of _____the sum of $_____and application for insurance to Guarantee Trust Life Insurance Company. If for any reason the application is declined this payment will be refunded. No liability is created or assumed by the company, except for refund of this payment, until the insurance applied for has been issued.

Agent's Signature:_____

If you do not receive your policy/certificate within 60 days from the date of your application, please write to:
Guarantee Trust Life Insurance Company, 1275 Milwaukee Avenue Glenview, IL 60025
MAKE CHECK PAYABLE TO: GUARANTEE TRUST LIFE INSURANCE COMPANY