Agent Name:

Phone:

GTL | GUARANTEE TRUST LIFE

Short-Term Home Health Care Insurance

APPLICANT INFORMATION PACKET

SOUTH DAKOTA

REQUIRED TO LEAVE WITH APPLICANT

INCLUDES:

- MEDDUP-2–Medicare Duplication Notice
- HIPAA– Notice of Privacy Practices
- OCG2370-SD– Home Health Care Outline of Coverage
- E-CONSENT– Electronic Delivery and Communications Disclosure

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

15A0669

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

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. 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 of the services covered by the policy are also covered by Medicare

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
- 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
1275 Milwaukee Avenue, Glenview, IL 60025
(800) 338-7452

SHORT-TERM HOME HEALTH CARE INSURANCE POLICY
OUTLINE OF COVERAGE

For Policy Form Series G2370-SD
With Optional Rider Forms RG15CA-SDR, RG16ASH-SD, RG16ASB-SD, RG12DV-SD, RG15RPDL, RG23CG

CAUTION: The issuance of the Policy is based on your answers to the questions on your application. A copy of your application will be attached to the Policy. Any omission or wrong statements in your application may result in your loss of coverage. If, for any reason, any of your answers are incorrect, contact us within 30 days at the address shown above.

If you have any questions concerning this coverage, or if we can be of any assistance, please call us at 1-800-338-7452.

NOTICE TO BUYER
THE POLICY MAY NOT COVER ALL OF THE COSTS ASSOCIATED WITH SHORT-TERM HOME HEALTH CARE INCURRED BY THE BUYER DURING THE PERIOD OF COVERAGE. THIS IS A LIMITED POLICY. THE BUYER IS ADVISED TO REVIEW CAREFULLY ALL POLICY LIMITATIONS AND EXCEPTIONS.

POLICY DESIGNATION
The policy is an individual policy of insurance.

PURPOSE OF OUTLINE OF COVERAGE
This outline of coverage provides a very brief description of some of the important features of the Policy. This is not the insurance contract, but only a summary of coverage. Only the individual Policy contains governing contractual provisions. This means that the Policy sets forth in detail those rights and obligations applicable to both you and Guarantee Trust Life Insurance Company. It is very important, therefore, that you **READ YOUR POLICY CAREFULLY**.

GUARANTEED RENEWABLE
This means you have the right, subject to the terms of the Policy, to continue the Policy as long as you pay your premium on time. We cannot change any of the terms of the Policy on our own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY. We may change your premium by giving you advance written notice, as required by state law. We can only do this when we change the premiums for all policies like yours in the state where you live.

THIS IS NOT MEDICARE SUPPLEMENT COVERAGE
If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from us. Neither Guarantee Trust Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

SHORT-TERM HOME HEALTH CARE INSURANCE
Policies of this category are designed to provide persons insured with limited or supplemental coverage.

The Policy provides coverage on an indemnity basis for Covered Home Health Care Services. All benefits are subject to the definitions, limitations and exclusions described in the Policy.

BENEFITS PROVIDED BY THE POLICY

Benefit Eligibility: To qualify for benefits, a Licensed Health Care Practitioner must provide us with written certification that: (i) you have a Cognitive Impairment or Functional Impairment, and (ii) Covered Home Health Care Services is/are needed pursuant to a Plan of Care.

BENEFIT ELIGIBILITY TERMS DEFINED:
Cognitive Impairment means a deterioration or loss in intellectual capacity resulting from Alzheimer's disease, dementia or other similar forms of permanent progressive disease that destroy memory and/or other important mental functions of a person such as thinking, sensing or reasoning and which requires Substantial Supervision to protect You from threats or actual harm to Your health and safety. Cognitive Impairment is evaluated and measured by clinical evidence and/or standardized tests that reliably measure impairment in one's: (1) short or long-term memory; (2) orientation as to people, places, or time; and/or (3) deductive or abstract reasoning.

Functional Impairment mean the inability to perform at least two (2) of the six (6) Activities of Daily Living, listed below, without Substantial Assistance.

Activities of Daily Living means the following six (6) basic activities of daily living:

1. **Continence:** The ability to maintain control of bowel or bladder function; or, if unable to maintain control of bowel or bladder function, the ability to perform associated care for a catheter or colostomy bag.
2. **Dressing:** The ability to put on or take off all items of clothing and, if applicable any necessary braces, fasteners or artificial limbs.
3. **Eating:** The ability to feed oneself by getting food into the body from a receptacle (e.g., plate, cup, table) or if fed by a feeding tube or intravenously, Your ability to properly use and maintain such feeding tube.
4. **Personal Hygiene:** The ability to clean oneself and perform grooming activities on oneself like shaving and brushing teeth.
5. **Toileting:** The ability to get to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. **Transferring:** The ability to move into or out of a bed, chair or wheelchair, or generally move from place to place, without assistance.

POLICY BENEFITS BY PLAN SELECTION: Listed below are the benefits provided by the Policy. Benefit payment for each Covered Home Health Care Service is based upon the plan you select.

COVERED HOME HEALTH CARE SERVICES *(Check applicant's selection)*	**PLAN SELECTION** ☐ **Plan A**	☐ **Plan B**	☐ **Plan C**
NURSING CARE SERVICES			
Skilled Nursing Care /Daily Benefit	$75	$150	$200
General Nursing Care / Daily Benefit	$60	$120	$200
THERAPY AND MEDICAL SOCIAL SERVICES			
Physical / Daily Benefit	$75	$150	$200
Speech / Daily Benefit	$75	$150	$200
Occupational / Daily Benefit	$75	$150	$200
Enterostomal / Daily Benefit	$50	$100	$200
Respirational / Daily Benefit	$50	$100	$200
Chemotherapy Specialist / Daily Benefit	$60	$120	$200
Medical Social Services / Daily Benefit	$100	$200	$300
HOME HEALTH AIDE SERVICES			
Home Health Aide/Daily Benefit	$50	$100	$150
COMBINED MAXIMUM DAILY BENEFIT AMOUNT FOR COVERED HOME HEALTH CARE SERVICES			
Combined Maximum Daily Benefit Amount for ALL above Covered Home Health Care Services, not to exceed:	$150	$300	$450
PRESCRIPTION DRUG BENEFIT*			
Generic/per Prescription Drug	$10	$10	$10
Brand / per Prescription Drug	$25	$25	$25
Prescription Drug Policy Year Maximum	$300	$600	$900

*****The Prescription Drug benefit is not subject to the Pre-Existing Condition Limitation and is payable without regard to eligibility for Covered Home Health Care Services.

MAXIMUM BENEFIT PERIODS: The Maximum Benefit Period for all Covered Home Health Care Covered Services is 360 days.

PRE-EXISTING CONDITIONS LIMITATION:
The Policy is subject to a 6 month Pre-Existing Condition limitation. Pre-Existing Condition means a Sickness or Injury, disclosed or not disclosed on the Application, for which medical care, treatment, diagnosis or advice was received or recommended within the 6 month period immediately prior to the Policy's Effective Date OR a condition that, within the 6 months prior to the Policy's Effective Date, manifests itself in such a manner that would cause an ordinarily prudent person to seek medical advice, diagnosis, care or treatment. Treatment includes, but is not limited to, being prescribed drugs or taking Prescription Drugs. Any Loss due to a Pre-Existing Condition is not covered unless the Loss begins during the 6 months after the Policy's Effective Date.

LIMITATION ON BENEFITS:

1.) Benefits paid for Covered Home Health Care Services are subject to: (a) the Combined Daily Maximum Benefit Amount; and (b) the Maximum Benefit Period.

2.) We will not pay more than the Maximum Benefit Period, unless benefits are restored according to the Policy's Restoration of Benefits provision.

3.) The Daily Benefit Amount for each Covered Home Health Care Service is only payable for the date the specific service is provided.

4.) For benefits to be payable, Covered Home Health Care Services must occur while the Policy is in force.

5.) When multiple Covered Home Health Care Services are received on a single Day, We will count only one Day toward the Maximum Benefit Period.

RESTORATION OF BENEFITS:

The Maximum Benefit Period for Covered Home Health Care Services will be fully restored when:

1.) Covered Home Health Care Services are not received for a period of 180 consecutive days; and
2.) A Licensed Health Care Practitioner has provided written certification that you have sufficiently recovered enough to no longer qualify as having either (i) a Functional Impairment or (ii) Cognitive Impairment **and** have been advised that (i) you no longer require Covered Home Health Care or (ii) other nursing or home care services, whether or not such services are covered under the terms of the Policy.

POLICY EXCLUSIONS:

The Policy will not pay benefits for Loss under the following circumstances:

1.) For the provision of services due to Injury or Sickness arising out of war or any act of war, declared or undeclared while serving in the military services or any auxiliary unit attached thereto;
2.) For the provision of services due to Injury or Sickness caused, or aggravated by, intentionally self-inflicted injuries, or attempted suicide while sane or insane;
3.) For the provision of services due to participation in a felony, riot or insurrection;
4.) For the provision of services due to Injury or Sickness arising out of or in the course of employment or which is paid under any workers' compensation or occupational disease act or law; or motor vehicle no-fault law;
5.) For the provision of services by a member of Your Immediate Family unless: (a) he or she is employed by the Home Health Care Agency; (b) the Home Health Care Agency receives payment for the services; (c) he or she receives no compensation other than the normal compensation for employees of the Home Health Care Agency, and (d) the family member is the only Doctor in the area and the Doctor is acting within the scope of his or her practice;
6.) For the provision of services not included in Your Plan of Care;
7.) For the provision of services which would not routinely be paid in the absence of insurance;
8.) For the provision of services received outside the United States or its possessions; or
9.) For the provision of services incurred prior to the Policy Effective Date, or on or subsequent to its termination or expiration date.

OPTIONAL RIDERS

CRITICAL ACCIDENT BENEFIT RIDER – FORM RG15CA-SDR

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

Initial Benefit Period: 30 days

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 48 hours of a covered Accident. Benefit payment is subject to a 30 day Initial Benefit Period. Benefits are a 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 Fracture, Dislocation and / or Knee Ligament / Meniscus Tear is sustained as a result of a covered Injury, only one 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 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, services or supplies which:
   a.) Are not prescribed by a doctor to treat an injury.
   b.) Are determined to be experimental / investigational in nature.
   c.) Are received without charge or legal obligation to pay.
   d.) Are received from persons employed or retained by any family member.
   e.) Are provided outside of an emergency room or urgent care facility.
2.) Fracture of fingers, toes, ribs or coccyx.
3.) Intentionally self-inflicted injury, violating or attempting to violate any duly enacted law.
4.) Injury being exposed to war or any act of war, declared or not, or participating in or contracting with the armed forces (including coast guard) of any country or international authority.
5.) 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.
6.) Cosmetic surgery, except for reconstructive surgery on an injured part of the body.
7.) Dental treatment.
8.) 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.
9.) Treatment of vegetation or ptomaine poisoning or bacterial infections, except pyogenic infections due to accidental open cuts; or accidental ingestion of contaminated substances.
10.) Suicide or attempted suicide while sane; or self-destruction or an attempt to self-destroy while insane.
11.) Injury resulting from testing cars/trucks on any racetrack or speedway.
12.) Injury resulting from participation in intercollegiate sports.
13.) Injury sustained while taking part in any of the following activities: as a rider in or driving in competitive motor sports, 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, para kiting, or bungee cord jumping.
14.) Participating in any sporting event for pay or prize money.
15.) Injuries incurred and resulting from hazardous occupations such as 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.
16.) Injuries arising out of or in the course of employment and which is paid under any workers' compensation or occupational disease act or law.
17.) Injuries incurred more than 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 60 days.

DENTAL AND VISION BENEFIT RIDER - FORM RG12DV-SD

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

This rider pays 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 Amount of $100;
- Insured Percent of covered expenses; and
- The 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.

This rider provides limited benefits during the first 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:

1.) A service not furnished by a Dentist, except:
   a.) That performed by a Dental Hygienist under the supervision of a Dentist.
   b.) X-rays ordered by a Dentist.
2.) Treatment, services or supplies which are:
   a.) Not Necessary Dental Treatment, except as provided herein.
   b.) Experimental/Investigational in nature.
   c.) Conditions paid by Workers' Compensation Services.
3.) Treatment by a Family Member unless such Family Member is the only Dentist or Doctor in the area and acting within the scope of practice.
4.) Services or supplies for which there would be no charge in the absence of insurance.
5.) A service furnished to You for:
   a.) Cosmetic purposes, unless needed as a result of Injury. Facing on crowns, on pontics, posterior to the second bicuspid shall always be considered cosmetic.
   b.) Dental care of congenital or developmental malformation (unless benefits for orthodontic services are specifically provided in the Schedule.)
6.) Implants; replacement of lost or stolen appliances, replacement of orthodontic retainers, athletic mouth guards, precision or semi-precision attachments; denture duplication; or sealants.
7.) Oral hygiene instructions; plaque control; acid etch; or prescription for take-home fluoride.
8.) Over dentures and associated procedures.
9.) Services not completed by the end of the month in which insurance terminates.
10.) Orthodontic related expense, unless specifically provided.

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

11.) Treatment, services or supplies which:
   a.) Are Experimental/Investigational in nature.
   b.) Are received without charge or legal obligation to pay.
   c.) Treatment by any Family Member unless such Family Member is the only Dentist or Doctor in the area and acting within the scope of practice.
12.) Conditions paid by Workers' Compensation Services.
13.) Services and supplies in connection with special procedures such as: orthoptics or vision training and subnormal vision aids.
14.) Non-prescription (plano) eyewear.
15.) Medical or surgical treatments of the eyes, unless to correct refraction of the eyes.
16.) Eye examinations required by an employer as a condition of employment.

RETURN OF PREMIUM UPON DEATH BENEFIT RIDER – Form RG15RPDL

This rider pays a return of premium benefit in the event of your death. The actual amount of premium that will be returned, if any, will equal:

1. The sum of all premiums paid for the policy, including premiums paid for this rider and any other benefits riders attached to the policy (unless expressly excluded), while this rider is in force (except for any application and annual policy fees.) The sum of all premiums is without interest accumulation. MINUS
2. The sum of all benefit paid or then payable under the policy, including benefits paid or then payable under any attached benefit riders while the rider was in force.

ACCIDENT AND SICKNESS HOSPITALIZATION BENEFIT RIDER - FORM RG16ASH-SD

Accident and Sickness Hospitalization Benefit: ☐ $100 ☐ $200 ☐ $300 / per day
Maximum Benefit Period: ☐ 3 ☐ 6 / days
Waiting Period for Covered Sickness: 30 Days

This rider pays an Accident and Sickness Hospitalization Benefit for:

1. A Loss incurred as a result of a covered Injury, which was initially treated in an Emergency Room or Outpatient Facility within 48 hours after the covered Injury occurred, and with admittance to a Hospital immediately following.
2. A Loss as a result of a covered Sickness. Benefits are payable only when:
   a. Incurred while the Policy and Rider are in force;
   b. The Waiting Period, if any, has been satisfied; and
   c. Not otherwise excluded from coverage under the Policy and Rider.

We will pay the Accident and Sickness Hospitalization Benefit Amount for each day of Hospital Confinement due to a covered Accident or Sickness. Benefits are not payable beyond the Maximum Benefit Period of Hospital Confinement for any One Period of Hospital Confinement.

The first Hospital Confinement Day for the Accident and Sickness Hospitalization Benefit Amount is payable upon a Hospital Confinement of at least 24 consecutive hours by reason of a covered Injury or Sickness, for which benefits are payable and there is a charge for room and board.

Any one continuous period of hospitalization which begins while the Rider is in force, won't be affected by the Policy or Rider terminating.

ACCIDENT AND SICKNESS HOSPITALIZATION BENEFIT RIDER EXCLUSIONS:

This rider does not provide benefits for Loss as a result of:

1.) Intentionally self-inflicted injury, violating or attempting to violate any duly enacted law.
2.) Injury being exposed to war or any act of war, declared or not, or participating in or contracting with the armed forces (including coast guard) of any country or international authority.
3.) 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.
4.) Suicide or attempted suicide while sane; or self-destruction or an attempt to self-destroy while insane.
5.) Injury to the spine, or the cervical, thoracic spinal, dorsal, sacro-iliac, or lumbar regions unless loss begins not less than 6 months after the covered person's effective date of coverage.
6.) Repetitive motion injuries, strains, all types of hernia, tendinitis, bursitis and heat exhaustion not related to a specific injury.
7.) Injury resulting from testing cars/trucks on any racetrack or speedway.
8.) Injury sustained while taking part in any of the following activities: as a rider in or driving in competitive motor sports, 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 ultra-light, hang gliding, parachuting, parasailing, parakiting, or bungee cord jumping.
9.) Participating in any sporting event for pay or prize money.
10.) Injuries incurred and resulting from hazardous occupations such as 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.
11.) Injuries arising out of or in the course of employment and which is paid under any workers' compensation or occupational disease act or law.
12.) Injuries incurred more than forty (40) miles outside the territorial limits of the United States or Canada, unless such loss is incurred while the covered person is on a trip of not more than sixty (60) days.
13.) Pregnancy, except for complications of pregnancy; or hospital confinement due to giving birth within the first nine (9) months after the effective date of coverage under this rider as a result of a normal pregnancy, including cesarean.

AMBULANCE SERVICE BENEFIT RIDER - FORM RG16ASB-SD

This rider pays an Ambulance Service Benefit of $200 if a licensed ground ambulance service transports you to or from a medical facility. The ambulance service must be Medically Necessary. This Benefit is payable no more than 4 times per Calendar Year and is subject to a lifetime maximum benefit of $2,500.

AMBULANCE SERVICE BENEFIT RIDER EXCLUSIONS

This rider does not pay benefits for:

1.) Services which are not Medically Necessary.
2.) Services which are received without charge or legal obligation to pay.
3.) Services which would not routinely be paid in the absence of insurance.
4.) Services received outside the United States.
5.) Loss as a result of war, or any action of war, declared or undeclared; service in the armed forces of any country.
6.) Loss incurred as a result of committing a felony or participating in a riot or civil commotion.
7.) Loss incurred as a result of suicide or intentionally self-inflicted injury while sane or insane.
8.) Injury or sickness arising out of or in the course of employment or which is paid under any workers' compensation or occupational disease act or law.

CAREGIVER BENEFIT RIDER – FORM RG23CG

This rider pays a fixed indemnity benefit when Covered Home Care services are provided to you, due to a Functional Disability, by an informal Caregiver.

Before the Caregiver Benefit Amount will be payable under this rider:

1. A Licensed Health Care Practitioner must certify that the Covered Home Care services are needed because you have a Functional Disability or are Functionally Disabled as defined within this rider;
2. You must undergo, and complete, an Assessment with a Qualified Caregiver Support Provider;
3. We must receive a copy of the Tailored Caregiver Plan of Care developed as a result of the Assessment; and
4. You must be receiving Covered Home Care.

Assessment means the process by which a Qualified Caregiver Support Provider, in cooperation with a Caregiver, develops a Tailored Caregiver Plan of Care that the Caregiver must comply with while performing your Covered Home Care.

Caregiver means a member of your Immediate Family, or other person, who, on a day-to-day basis, provides at least one (1) hour of Covered Home Care directly to you in your Home. A Caregiver does not include a person who qualifies as a Home Health Care Practitioner, as defined by the Short-Term Home Health Care Benefit Rider, if such rider is attached to your Policy.

Covered Home Care means medical and non-medical services and/or treatments (as described below) provided to you, in strict accordance with a Tailored Caregiver Plan of Care, by a Caregiver in your Home. Medical and non-medical services and treatments include nursing care, physical therapy, occupational therapy, speech therapy, nutritionist services, meal preparation, laundry, light housekeeping, shopping for food, medications or medical supplies, and transportation to and from appointments. Covered Home Care is incurred on the date the service and/or treatment is provided. Covered Home Care must occur while this rider is in force. Any service and/or treatment provided prior to the Effective Date of this rider, or after this rider has terminated, is not Covered Home Care.

Functionally Disabled/Functional Disability means an Insured who is:

1. Unable to perform at least 2 Activities of Daily Living without human assistance or supervision; or
2. Requires Substantial Supervision to protect such individual from threats to one's health and/or safety due to Cognitive Impairment.

Qualified Caregiver Support Provider means an entity who utilizes a caregiver support platform that has been reviewed, and determined to be an evidence-based program, by the U.S. Department of Health and Human Services.

BENEFITS PROVIDED BY THE CAREGIVER RIDER

Caregiver Benefit Amount: $ 3,500

Caregiver Benefit Lifetime Maximum: $ 7,000

LIMITATIONS ON CAREGIVER BENEFITS

In addition to exceptions contained within the Policy, we will not pay the Caregiver Benefit Amount under this rider for:

1. Services or treatments provided prior to the Effective Date of this rider;
2. Services or treatments provided after the termination of this rider;
3. Services or treatments provided outside a Period of Care;
4. Services or treatments provided by an individual for which benefits have been paid under your policy or any other rider attached to your Policy;
5. Services or treatments which are inconsistent with, or not included within, the Tailored Caregiver Plan of Care;
6. Services or treatments provided during Days in which you do not receive at least one (1) hour of Covered Home Health Care;
7. Services or treatments which are the result of a pre-existing condition in accordance with the Policy's provisions relating to pre-existing conditions; or
8. Services or treatments resulting from an Assessment completed by a Qualified Caregiver Support Provider that is (1) owned, or operated, by a member of your Immediate Family or (2) a business entity that you or your Immediate Family have a financial interest in or business relationship with.

INITIAL PREMIUM

COVERAGE DESCRIPTION	PREMIUM
Short-Term Home Health Care Policy *(Check box for Plan selected)* ☐ Plan A ☐ Plan B ☐ Plan C	$_____
Accident and Sickness Hospitalization Benefit Rider	$_____
Ambulance Service Benefit Rider	$_____
Critical Accident Benefit Rider	$_____
Dental / Vision Benefit Rider	$_____
Return of Premium Upon Death Benefit Rider	$_____
Caregiver Benefit Rider	$_____
Policy Fee:	$ 20.00
TOTAL PREMIUM:	$_____

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.