

**Application for Short-Term Nursing Home Care Indemnity Insurance Policy**  
**Guarantee Trust Life Insurance Company**  
 1275 Milwaukee Avenue Glenview, IL 60025 (800) 338-7452

**(A) AGENT NOTE: Please pre-qualify the Applicant (s) with Section C prior to completing the application.**

**Application for:**    **New Coverage**    **Reinstatement**    **Increase of Benefits**  
 If Reinstatement or Increase requested, please list GTL policy/certificate number(s) affected: \_\_\_\_\_  
**APPLICANT(S) INFORMATION** **MAIL POLICY TO:**    **AGENT**    **INSURED**

**Applicant 1**

1. Last Name \_\_\_\_\_ 2. First \_\_\_\_\_ 3. M.I. \_\_\_\_\_  
 4. Social Security # \_\_\_\_\_ 5. Age \_\_\_\_\_ 6. Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 7. Height (ft/in) \_\_\_\_\_ 8. Weight \_\_\_\_\_ lbs 9.  Male  Female

**Applicant 2**

10. Last Name \_\_\_\_\_ 11. First \_\_\_\_\_ 12. M.I. \_\_\_\_\_  
 13. Social Security # \_\_\_\_\_ 14. Age \_\_\_\_\_ 15. Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 16. Height (ft/in) \_\_\_\_\_ 17. Weight \_\_\_\_\_ lbs 18.  Male  Female

**Address**

19. Street Address \_\_\_\_\_ 20. City \_\_\_\_\_ 21. State \_\_\_\_ 22. Zip Code \_\_\_\_\_  
 23. Applicant 1 E-mail \_\_\_\_\_ 24. Applicant 2 E-mail \_\_\_\_\_  
 25. Applicant 1 Phone \_\_\_\_\_ 26. Applicant 2 Phone \_\_\_\_\_

**(B) Plan Applied For Applicant 1**

**Nursing Home/Assisted Living Facility**

1. **Select Daily Benefit Amount:**  
 \$50 - \$300/day (in \$10 dollar increments): \$ \_\_\_\_\_  
 2. **Benefit Period:**  
 30    45    60    90    180    360 Days  
 3. **Elimination Period:**  
 0 Days    20 Days

**(B) Plan Applied For Applicant 2**

**Nursing Home/Assisted Living Facility**

8. **Select Daily Benefit Amount:**  
 \$50 - \$300/day (in \$10 dollar increments): \$ \_\_\_\_\_  
 9. **Benefit Period:**  
 30    45    60    90    180    360 Days  
 10. **Elimination Period:**  
 0 Days    20 Days

**Inflation Rider**

4.  5% Simple Inflation    5% Compound Inflation

**Inflation Rider**

11.  5% Simple Inflation    5% Compound Inflation

**Home Health Rider:**

5. **Benefit Period:**  
 90 Visits    180 Visits  
 6. **Benefit Amount Per Visit:**  \$25    \$50    \$75  
 7. **Elimination Period:**  0 Days    20 Days

**Home Health Rider:**

12. **Benefit Period:**  
 90 Visits    180 Visits  
 13. **Benefit Amount Per Visit:**  \$25    \$50    \$75  
 14. **Elimination Period:**  0 Days    20 Days

**Choose Premium Payment Mode:**

Monthly Bank Draft    Annual    Semi-Annual  
 Quarterly  
 Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Draft Date: (other than the 29th, 30th and 31st) \_\_\_\_\_

**Premiums:**

Premiums include an annual \$25 Policy Fee (per applicant)  
 Applicant 1 Total Premium: \$ \_\_\_\_\_  
 Applicant 2 Total Premium: \$ \_\_\_\_\_

<b>(C) Pre-Qualification, Medical Information &amp; Exclusions</b>				<b>Applicant 1</b>	<b>Applicant 2</b>
<b>If any applicant answers "YES" to any questions 1, 2 or 3 A-H below, that applicant does not qualify for this coverage:</b>					
1. Is any applicant currently eligible for Medicaid or on early Medicare due to disability (prior to age 65) or disabled?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. In the past 10 years has any applicant been treated or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. In the past 24 months, has any applicant:					
A. Required the assistance or supervision of any kind to perform activities of daily living such as bathing, dressing, eating, toileting, getting in or out of bed or chair; have an inability to control bowel or bladder function; or need or use a wheelchair, walker, walking aids, scooter, or multi-pronged cane?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
B. Been confined or advised to enter a rehabilitation facility, nursing facility or assisted living facility; or received home health care services?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
C. Had a stroke, Transient Ischemic Attack (TIA); or congestive heart failure, heart or valve surgery or organ transplant (other than corneal)?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
D. Been diagnosed with, or treated for, insulin dependent diabetes or diabetes with neuropathy or with eye or kidney complications?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
E. Been diagnosed or treated for Alzheimer's disease, dementia, memory loss, Parkinson's disease, psychotic disorders, systemic lupus, Multiple Sclerosis, Muscular Dystrophy, cerebral palsy, ALS (Lou Gehrig's disease), or had an amputation due to a disease?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
F. Been diagnosed or treated for Chronic Obstructive Lung or Pulmonary disease; chronic bronchitis or emphysema; respiratory disease requiring the use of oxygen; kidney failure, renal insufficiency, or kidney dialysis; or chronic liver disease?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
G. Been diagnosed or treated for cancer (other than skin cancer), leukemia, lymphoma or malignant melanoma or cancer that has spread from its original site; or alcohol or drug abuse or crippling or rheumatoid arthritis?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
H. Been advised to have tests or medical treatment or surgery that has not been performed or for which results have not been given?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. In the past 12 months has any applicant used any tobacco products?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. <b>Has any applicant taken any prescription medications during the past 6 months?</b>				Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>If yes, complete medication chart below:</b>					
<b>Name</b>	<b>Medication</b>	<b>Reason Prescribed</b>	<b>Name, Address of Doctor</b>		

<b>(D) Applicant(s) Coverage Information:</b>	
1. Will any existing in force hospital, medical, or major medical insurance be replaced or changed if the proposed coverage is issued? (If "YES," please complete the Replacement Form)	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "Yes," For Which Applicant? _____	
For Which Company? _____	

## ACKNOWLEDGEMENTS & AUTHORIZATION

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 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 insurance applied for will not become effective until: a) approved and issued by GTL; b) I (We) have been furnished written notice of the effective date; and c) I (We) have paid the premium in full. 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. If this application is completed electronically, I (We) understand the Pre-Notice will be delivered electronically or with the policy. If the application is completed over the phone the Pre-Notice will be delivered with the policy.

**AUTHORIZATION:** 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 any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. 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, Veterans Administration, insurance company, pharmacy benefit managers, pharmacies, pharmacy-related facilities or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from MIB. I (We) authorize the Company, or its reinsurers, to make a brief report of my (our) personal health information to MIB. 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.

I (We) have received an Outline of Coverage. If this application is completed electronically, I (We) understand the Outline of Coverage will be delivered electronically or with the policy. If the application is completed over the phone the Outline of Coverage will be delivered with the policy. 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.

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Signed at: \_\_\_\_\_  
Date City State

\_\_\_\_\_  
Applicant #1 Signature

\_\_\_\_\_  
Applicant #2 Signature (if applicable)

**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. To the best of my knowledge and belief, the insurance applied for  is or  is not likely to replace or change existing insurance or annuities.

\_\_\_\_\_  
Agent's Name (Printed) E-mail Address Agent Code  
\_\_\_\_\_  
Agent's Signature Date

APPH9-11

**MONTHLY 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 Code

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

Account # \_\_\_\_\_ Bank Routing # \_\_\_\_\_  
Account Type:  Checking Account (*Attach a Voided "Sample" check*)  Savings Account (*Attach a Voided "Sample" check if applicable, or a Deposit slip*)

I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I 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

**NOTICE TO APPLICANT – PARTS 1 AND 2**

**Part 1: 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 concerning 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 discussed 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 used a “consumer reporting agency,” you have the right to: (1) ask to talk with 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 of 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.

**Part 2: Notification Regarding Medical Information Bureau**

Information regarding your insurability will be treated as confidential. Guarantee Trust Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB, Inc.’s file, you may contact the MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address to the MIB information office is 50 Braintree Hill Park, Suite 400, Braintree Massachusetts 02184-8734, telephone number (866) 692-6901, e-mail address infoline@mib.com. Guarantee Trust Life Insurance Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

**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**

## **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. GTL is required by law to provide you with certain 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 may 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.

\* Not all items listed above may be immediately available as an Electronic Record and available for viewing in our Customer Portal. As additional Electronic Records become available, the Customer Portal will alert you to the new viewing options and allow you the opportunity to update your Customer Communication settings.

#### **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](http://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.

### **STATEMENT OF CONSENT**

#### **I AGREE**

By clicking "I agree" and / or providing GTL with your email address, you are consenting to the use of Electronic Records and Electronic Signatures. 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.