Application for Short-Term 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 **SEND 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 and Home Health Care

1. Select Daily Benefit Amount:
$50 - $300/day (in $10 dollar increments): **$** _________

2. Benefit Period:
☐ 100 ☐ 200 ☐ 300 Days

3. Elimination Period:
☐ 0 Days ☐ 20 Days

Inflation Protection Benefit Rider

4. ☐ 3% Compound Inflation

(B) Plan Applied For Applicant 2

Nursing Home/Assisted Living Facility and Home Health Care

5. Select Daily Benefit Amount:
$50 - $300/day (in $10 dollar increments): **$** _________

6. Benefit Period:
☐ 100 ☐ 200 ☐ 300 Days

7. Elimination Period:
☐ 0 Days ☐ 20 Days

Inflation Protection Benefit Rider

8. ☐ 3% Compound Inflation

I (We) have reviewed the Outline of Coverage and graphs that compare the benefits and premiums of this policy with and without the Compound Inflation Protection benefit rider and I (we) reject optional inflation protection coverage.

PLEASE INITIAL IF APPLICABLE:

App 1: __________ App 2: __________

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: $ __________

(C) Pre-Qualification, Medical Information & Exclusions	Applicant 1	Applicant 2
If any applicant answers "YES" to any questions 1, 2 or 3 A-H below, that applicant does not qualify for this coverage:		
1. Is any applicant currently eligible for Medicaid or on early Medicare due to disability (prior to age 65) or disabled?	Yes☐ No☐	Yes☐ No☐
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☐ No☐	Yes☐ No☐
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☐ No☐	Yes☐ No☐
B. Been confined or advised to enter a rehabilitation facility, nursing facility or assisted living facility; or received home health care services?	Yes☐ No☐	Yes☐ No☐
C. Had a stroke, Transient Ischemic Attack (TIA); or congestive heart failure, heart or valve surgery or organ transplant (other than corneal)?	Yes☐ No☐	Yes☐ No☐
D. Been diagnosed with, or treated for, insulin dependent diabetes or diabetes with neuropathy or with eye or kidney complications?	Yes☐ No☐	Yes☐ No☐
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☐ No☐	Yes☐ No☐
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☐ No☐	Yes☐ No☐
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☐ No☐	Yes☐ No☐
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☐ No☐	Yes☐ No☐
4. In the past 12 months has any applicant used any tobacco products?	Yes☐ No☐	Yes☐ No☐

5. Has any applicant taken any prescription medications during the past 6 months? Yes☐ No☐
If yes, complete medication chart below:

Name	Medication	Reason Prescribed	Name & Address of Doctor

(D) Existing Coverage–Please give complete details to any "YES" answers in this section	Applicant 1	Applicant 2
Check all boxes that apply to the following questions:		
1. Are you covered by Medicaid?	Yes☐ No☐	Yes☐ No☐
2. Do you have a Long Term Care or another Short-Term Care insurance policy or certificate in force (including a health care service contract or health maintenance organization contract)?	Yes☐ No☐	Yes☐ No☐
3. Have you had a Long Term Care or another Short-Term Care insurance policy or certificate during the last twelve (12) months? If so, with which company? If that policy lapsed, when did it lapse?	Yes☐ No☐	Yes☐ No☐

If "YES", with which company?

App.1 ______________________________

If "YES", with which company?

App.2 ______________________________

What date did the coverage lapse?

App.1 ______________________________

What date did the coverage lapse?

App.2 ______________________________

4. Do you intend to replace any of your medical or health insurance coverage with this policy?	Applicant 1	Applicant 2
	Yes☐ No☐	Yes☐ No☐

If "YES", with which company? App.1 ____________________________ Policy#____________________________

If "YES", with which company? App.2 ____________________________ Policy#____________________________

Agent: If "YES", be sure to fill out the proper replacement forms required by your state. Leave a copy with the Applicant(s) and send one copy with the application.

Applicant 1	Applicant 2	List all policies or certificates you have sold to the Applicant(s) which are still in force:		List all policies or certificates the Applicant(s) has which are still in force or applied for:		List all policies or certificates you have sold to the Applicant(s) within the past 5 years which are no longer in force:	
		NAME OF INSURER	POLICY #	NAME OF INSURER	POLICY #	NAME OF INSURER	POLICY #
☐	☐						
☐	☐						
☐	☐						

List any additional policies on a separate paper signed by the Applicant(s).

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, INTENTIONAL 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. 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.

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, pharmacies or pharmacy-related facility which have 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 this authorization will be valid for 24 months from the date signed. 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.

This application may be completed by electronic means. I (We) acknowledge that the Company or its agent has verified my (our) identity for this purpose in accordance with any applicable law or regulation and that if completed by electronic means, I (We) have provided my (our) consent and authorization to complete an electronic transaction to apply for coverage. This authorization shall constitute an electronic signature, which is legally binding, and has the same effect as if I (we) had physically signed this application.

I (We) agree that I (we) may receive my (our) policy and other GTL correspondence in electronic format. I (We) acknowledge receipt of the Electronic Delivery and Communications Disclosure, which describes the requirements for Electronic Policy Fulfillment and Communications, as well as my (our) right to opt-out of Electronic Policy Fulfillment and receive a paper copy of my (our) policy (policies), free of charge.

RECEIPT: I (We) have received a brochure and the following information when I (we) applied for insurance under this policy issued by Guarantee Trust Life Insurance Company:

- ☐ Outline of Coverage
- ☐ Description of Information Practices (in states where required).
- ☐ Guide to Health Insurance for People with Medicare (if eligible for Medicare)
- ☐ Notice About Your Rights Under the Fair Credit Reporting Act

Any person who knowingly and with intent to defraud an insurance company or other person files an application for insurance containing any materially false information or conceals for the purpose of misleading information concerning any fact material thereto commits a fraudulent act, which is a crime. Any person who is already covered by Medicaid should not purchase this coverage.

CAUTION: If your answers on this application are incorrect or untrue, Guarantee Trust Life Insurance Company has the right to deny benefits or rescind your policy.

Applicant 1 Signature ______________________________

Signed at: City and State: ______________________ Date: ____________

Applicant 2 Signature (If Applicable) ______________________________

Signed at: ______________________ Date: ____________

APPH6-17-CT

PROTECTION AGAINST UNINTENTIONAL LAPSE

YOU WILL RECEIVE NOTICE IF YOUR POLICY IS ABOUT TO LAPSE (TERMINATE) BECAUSE YOU HAVE NOT PAID PREMIUMS. WE WILL BE GLAD TO SEND A COPY OF THIS NOTICE TO ANOTHER PERSON, IF YOU WOULD LIKE. THAT PERSON WILL NOT BE RESPONSIBLE FOR PAYMENT OF THE PREMIUM, AND YOU WILL ALWAYS RECEIVE YOUR OWN COPY OF THE NOTICE. IF YOU WANT AN EXTRA COPY SENT TO ANOTHER PERSON, PLEASE GIVE US THAT PERSONS NAME AND ADDRESS.

APPLICANT 1

☐ I designate the following person to be notified of the lapse in my policy:

Name of Designee

Street Address

City State Zip

☐ I choose NOT to designate any person to receive notice of the lapse in my policy.

APPLICANT 1 Signature Date

APPLICANT 2

☐ I designate the following person to be notified of the lapse in my policy:

Name of Designee

Street Address

City State Zip

☐ I choose NOT to designate any person to receive notice of the lapse of my policy.

APPLICANT 2 Signature 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. I have made reasonable efforts to obtain information concerning the applicant's health and financial information. Based on the information provided by the applicant, I believe this is a suitable purchase for the applicant's insurance needs. 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

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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

-- *Detach the below Notice to Applicant and Receipt and leave with applicant*--

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

Description of Information Practices

The Description of Information Practices is being provided by GUARANTEE TRUST LIFE INSURANCE COMPANY in accordance with the requirements of the Insurance Information and Privacy Protection law in effect (if required) in your state of residence. Your application, in most instances, gives us all needed information. However, in some cases, we may need to obtain more information by contacting other sources. This information, as well as other personal or privileged information collected, may in certain circumstances, be disclosed to third parties without your authorization, but only to the extent permitted by law. You have the right to access and correct all personal information collected. This notice is not intended to be a complete description of your rights. For a complete description of our information practices, please write:

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 <u>not</u> 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.

<u>Types of Electronic Records Covered by This Consent</u>
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.

<u>What You Need in Order to Receive or View Electronic Records</u>
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.