**G·T·L**

*CRITICAL PROVIDER*

**APPLICATION FOR LIFE INSURANCE TO: GUARANTEE TRUST LIFE INSURANCE COMPANY**

1275 Milwaukee Avenue - Glenview, Illinois 60025

| 1a. Proposed Insured (P.I.) #1 | Social Security # | Sex | Birth Date | Age | Birthplace | Height | Weight |
|---|---|---|---|---|---|---|---|
| (First, Middle & Last) | | | Mo. Day Yr. | | | | |

Occupation _____ Duties _____ Length of Current Employment _____

*Primary Beneficiary* *Relationship* *Contingent Beneficiary* *Relationship*

| 1b. Proposed Insured (P.I.) #2 | Social Security # | Sex | Birth Date | Age | Birthplace | Height | Weight |
|---|---|---|---|---|---|---|---|
| (First, Middle & Last) | | | Mo. Day Yr. | | | | |

Occupation _____ Duties _____ Length of Current Employment _____

*Primary Beneficiary* *Relationship* *Contingent Beneficiary* *Relationship*

**1c. Address** (Street, City, State & Zip Code)

_____E-Mail Address _____

Phone Number: Home ( ) _____ Work ( ) _____

**2. Select Plan Coverage:**

| | | |
|---|---|---|
| **Proposed Insured #1** | **Plan Applied For:**<br>☐ 10 Year Term with Full Critical Illness Coverage<br>☐ 10 Year Term with Limited Critical Illness Coverage<br>☐ 20 Year Term with Full Critical Illness Coverage*<br>☐ 20 Year Term with Limited Critical Illness Coverage*<br>**Term to 70 for ages 51-60*<br>Face Amount $_____ Money Purchase $_____<br>*(For Proposed Insured under age 20, Face Amount is $5,000 or $10,000 only)* | **Optional Benefit Riders:**<br>☐ Accidental Death Benefit Rider<br>*(Available for ages 20 and over)*<br>☐ Waiver of Premium Rider<br>*(Available for ages 20 and over)*<br>☐ Return of Premium Rider<br>*(Available with 20 Year Term Plan only and for ages 0-50)* |
| **Proposed Insured #2** | **Plan Applied For:**<br>☐ 10 Year Term with Full Critical Illness Coverage<br>☐ 10 Year Term with Limited Critical Illness Coverage<br>☐ 20 Year Term with Full Critical Illness Coverage*<br>☐ 20 Year Term with Limited Critical Illness Coverage*<br>** Term to 70 for ages 51-60*<br>Face Amount $_____ Money Purchase $_____<br>*(For Proposed Insured under age 20, Face Amount is $5,000 or $10,000 only)* | **Optional Benefit Riders:**<br>☐ Accidental Death Benefit Rider<br>*(Available for ages 20 and over)*<br>☐ Waiver of Premium Rider<br>*(Available for ages 20 and over)*<br>☐ Return of Premium Rider<br>*(Available with 20 Year Term Plan only and for ages 0-50)* |

**3. Billing Information:** Amount of Premium Collected: PI #1 $_____ PI #2 $_____

Premium Mode: ☐ Annual ☐ Semi-Annual ☐ Quarterly ☐ Monthly PAC ☐ List Bill Monthly

Mail Premium Notices to: ☐ Owner ☐ Premium Payor Group Number _____

**Owner** (if other than Proposed Insured):

Name _____ Relationship_____

Address _____ Social Security Number _____

**Premium Payor** (if other than Proposed Insured):

Name _____ Relationship _____

Address_____

| | Proposed Insured: #1 | #2 |
|---|---|---|
| **4.** Will this policy applied for replace or change any existing life insurance or annuity in force? If yes, please give details and submit any required replacement forms. | ☐Yes ☐No | ☐Yes ☐No |

**If the answer to any part of questions 5a-10 is "Yes", that proposed insured does not qualify for this plan.**

| | Proposed Insured #1 | #2 |
|---|---|---|
| **5. In the past 10 years, has anyone proposed for insurance had, been told they had, received treatment or medical advice by a medical practitioner for any of the following conditions:** | | |
| **(a)** Leukemia, malignant melanoma, lymphoma, sarcoma, or any other type of cancer (excluding skin cancer) or any tumor of the brain? | ☐Yes ☐No | ☐Yes ☐No |
| **(b)** Disease of the heart or heart valves, heart attack, coronary bypass, angioplasty, stent placement, angina, heart arrhythmia requiring treatment, cardiomyopathy, congenital heart defect, abnormal heart test or high blood pressure requiring the use of 3 or more medications? | ☐Yes ☐No | ☐Yes ☐No |
| **(c)** Stroke, Transient Ischemic Attack (TIA), peripheral vascular disease, aneurysm, brain hemorrhage, anemia (other than iron deficiency), major organ transplant or diabetes treated with insulin, or diabetes diagnosed before age 35 or diabetes diagnosed over 10 years ago? | ☐Yes ☐No | ☐Yes ☐No |
| **(d)** Optic neuritis, macular degeneration, Parkinson's disease, paralysis, dementia, Alzheimer's disease, mental retardation, multiple sclerosis, muscular dystrophy, Huntington's disease, Motor Neuron disease, cystic fibrosis or cerebral palsy? | ☐Yes ☐No | ☐Yes ☐No |
| **(e)** Chronic kidney, liver, respiratory or lung disease, schizophrenia or other psychosis, chronic depression, scleroderma, systemic lupus erythematosus, ulcerative colitis or Crohn's disease? | ☐Yes ☐No | ☐Yes ☐No |
| **6.** In the past 10 years, has anyone proposed for insurance tested positive or been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS); or the HIV virus? | ☐Yes ☐No | ☐Yes ☐No |
| **7.** In the past 5 years, has anyone proposed for insurance been treated for drug or alcohol abuse or abused alcohol or drugs or had abnormal test results relating to alcohol or drug use or been convicted of a felony or had your license revoked or suspended? | ☐Yes ☐No | ☐Yes ☐No |
| **8.** In the past 5 years, has anyone proposed for insurance participated or plan to participate in mountain climbing, hang gliding, parachuting, water or land racing, or flown as a private pilot or crew member? | ☐Yes ☐No | ☐Yes ☐No |
| **9.** In the past 12 months, has anyone proposed for insurance had any abnormal diagnostic test results, awaiting test results, or been advised to have any diagnostic test (including self-administered), or had a medical condition, symptom or abnormality for which you have not yet sought medical treatment or advice? | ☐Yes ☐No | ☐Yes ☐No |
| **10.** For anyone proposed for insurance, did 2 or more of your natural parent(s), sister(s), brother(s), either living or dead suffer from diabetes, cancer, stroke, heart disease, kidney disease, paralysis or any hereditary disease before the age of 60? | ☐Yes ☐No | ☐Yes ☐No |
| **11.** During the past 12 months has anyone proposed for insurance used any tobacco products? | ☐Yes ☐No | ☐Yes ☐No |
| **12.** Is any person proposed for insurance taking any prescription medication? If yes please list below: | ☐Yes ☐No | ☐Yes ☐No |

| Name of Person | Name of Medication(s) | Reason for Medication (s) | Dosage |
|---|---|---|---|
| | | | |
| | | | |
| | | | |

NOTE: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application containing a false, incomplete, or deceptive statement of a material fact may be guilty of insurance fraud.

**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, such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company 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 division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from the Medical Information Bureau. This Authorization includes all information about drugs, alcoholism, and mental illness. I (We) authorize all sources, except the Medical Information Bureau Inc. to give such records to any agency employed by Guarantee Trust Life Insurance Company to collect such information. 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 read or had read this authorization and I (we) have also received a copy or will be provided a copy of the "Notice to Applicant, Parts 1 and 2" and the Description of Information Practices form prepared by Guarantee Trust Life Insurance Company (if required in your state).

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.

I certify that I have asked all questions and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for ☐ is likely, or ☐ is not likely to replace or change existing insurance or annuities.

I hereby agree that: (1) all statements and answers in this application are complete and true, to the best of my knowledge and belief; and (2) no insurance will be effective until the policy is issued by the Company.

**X**_____ _____
Signature of Soliciting Agent Agent No.
*(Agent's signature not required if not sold through agent)*

**Signed at** _____ _____
City State/ZIP Date

**X**_____
Signature of Proposed Insured #1

**X**_____
Signature of Proposed Insured #2

**X**_____
Signature of Owner (if other than Proposed Insured)

_____ _____
Please Print Agent Name Above Agent E-Mail Address

Mail policy to: ☐ Agent ☐ Insured



Office Use Only: Market Code X

**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 ☐ Savings Account

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 obtain 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 obtain 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 the MIB, Inc.**

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 not-for-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another bureau 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 form 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 them and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may contact the MIB, Inc. at 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:

**MAKE CHECK PAYABLE TO: GUARANTEE TRUST LIFE INSURANCE COMPANY**