Value Med Plan

Benefits are Paid Directly to You!

◆ HOSPITAL ◆

$1000 Daily Hospital Benefit

from the first day to $365,000.00!

Also options for $500 per day or $100 per day

Dependent Children limited to $100 per day option

◆ DOCTOR'S OFFICE ◆

OFFICE VISITS $75.00 PER VISIT!

Pays for any practitioner of the healing arts!

◆ OUTPATIENT ◆

$100.00 Per Sickness or Injury!

X-Rays, Lab Tests, Medical Supplies & Much More

Pays in the doctor's office, lab or any other outpatient facility

for each covered adult and child

◆ *PAYS IN ADDITION TO OTHER INSURANCE* ◆

◆ *NO PPO & NO HMO* ◆

◆ *NO DEDUCTIBLE OR CO-PAYS* ◆

◆ *GUARANTEED RENEWABLE TO AGE 65* ◆

Underwritten By: United National Life Insurance Company Of America in AR, ID, IL, MO, NE, NV, NM, ND, OK, SD, TN, TX. Group Policy #UP2005, UT Policy Form U0552-UT, AR Policy Form U0552-AR, OK Policy Form U0552-OK, SD Policy Form U0552-SD, WV Policy Form U0552

OFFERED TO VBA MEMBERS
Value Benefits of America
a Not-For-Profit Association

Underwritten By: Guarantee Trust Life Insurance Company in All Other States Where Approved. Group Policy #GP2005, LA Policy Form G0551-LA, ME Policy Form G0551-ME, OR Policy Form G0551-OR, SC Policy Form G0551-SC, MD Policy Form G0551-MD

GTL

Pre-Existing Condition Limitation

Pre-existing conditions are those medical conditions disclosed or not disclosed on the application which were diagnosed or for which medical advice or treatment was recommended or received from a Doctor within a 12 month period (6 months in ID, NV, ND and OR, and 90 days in WY) immediately preceding the Effective Date of a Covered Person's Coverage. Any loss due to a pre-existing condition is not covered unless the loss begins more than 12 months after the Effective Date of a Covered Person's Coverage.

Exceptions and Limitations

We WILL NOT pay for charges incurred:

1. due to war or act of war whether declared or not; (Except in **OK**)
2. due to intentionally self-inflicted injury;
3. due to Mental Illness or nervous disorders without demonstrable organic disease (Loss due to Parkinson's Disease, Alzheimer's or senile dementia is covered) Except in **VT**; **In DC:** *due to Mental Illness or nervous disorders without demonstrable organic disease, except as state mandated (Loss due to Parkinson's Disease, Alzheimer's or senile dementia is covered)*
4. for normal pregnancy and child birth. Complications of pregnancy are covered as a sickness;
5. for treatment of an injury that results form the Covered Person's commission of, or attempt to commit a felony, or from the Covered Person being engaged in an illegal activity; ***In NE:*** *being engaged in an illegal occupation;* ***In VT:*** *treatment of an injury that results from your participation in a felony;*
6. for cosmetic surgery, but "cosmetic surgery" does not include reconstructive surgery that is incidental because of pervious surgery due to trauma, infection, or other disease of the involved part;
7. for confinement in a Hospital located or care received outside of the territorial limits of the United States of America, its commonwealth partners, or the countries of Canada and Mexico;
8. for the Covered Person being intoxicated or under the influence of alcohol or a narcotic; unless administered on the advice of a Physician or as state mandated. **IN NV:** *substance abuse, including alcoholism, drug addiction, narcotics or hallucinogens.*

In OK, *We will also not be liable for any loss sustained or contracted in consequence of Your being under the influence of any narcotic, unless administered on the advice of a Doctor.*

Benefit Limitations

1. Outpatient Benefit is $100.00 per sickness or injury up to $200.00 per calendar year per covered adult and for each covered child.
2. Doctor's office visits are limited to 10 per calendar year for adults, 5 per calendar year for all children combined.
3. Doctor's office calls are limited to one visit per week, except in Maryland.
4. Lifetime maximum is 365 days of hospital indemnity benefits paid.
5. Ambulance Benefit is $200.00 per sickness or accident.

Stable Premiums

Your premiums cannot be changed due to declining health. Your premiums can only be changed if we change the premiums of all like policies in your state. You will be notified before any changes are made.

- Association membership is not permitted in OR

MARKETED BY:

www.FreedomBenefits.net
Tony Novak
(800) 609-0683x1

Mail Completed Applications To:

General Agent Center
15575 North 79th Place, Suite 100
Scottsdale, Arizona 85260
Phone (800) 366-2467 Fax (800) 471-7996

Members receive up to 12 CallMD calls per year/per family!*

CALLMD™

Feel better today.
Stay healthy for tomorrow.

Have You Ever…

- *Needed a doctor in the evenings or on the weekends?*
- *Needed a prescription called in to your pharmacy?*
- *Needed to talk to a doctor about a non-emergency illness?*

AVOID unnecessary & costly Urgent Care or ER visits simply by contacting CallMD!

CallMD Doctors can write prescriptions!**

CallMD physicians provide medical advice, diagnosis and treatments in one-on-one phone consultations 24 hours a day, 7 days a week.

◆ Cost of consultations* with a CallMD Doctor is INCLUDED in your VBA membership. ◆

- **Save time at work or while at home when a doctor consultation is needed for you or members of your family.**
- **Electronic medical record maintained in a highly secured Internet accessible environment available to network doctors prior to consultation.**

CallMD has English and Spanish language services available!

Common health conditions treated by Call MD Doctors:

- Fever / sore throat
- Nasal congestion / cough
- Ear ache / Bronchitis
- Allergies
- Diabetes

CallMD is Not Insurance. Benefit Effective 30 Days After Date of VBA Membership. CallMD is not a replacement service for medical emergencies. In the event of a life-threatening health emergency, members should call 911 or their local emergency services first. *UP to the maximum of 12 consultations per year/per family OR 6 per year/per individual. Additional Consultations may be purchased by member for $35/consultation. **No DEA Controlled Substances or Narcotics Allowed.

VBA Membership is not available in all states.

VBA membership also includes:

Value Benefits of America
a Not-For-Profit Association

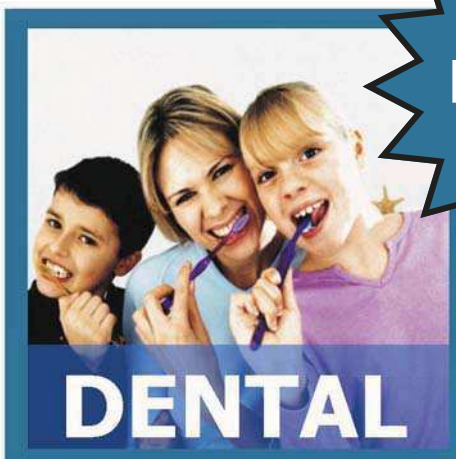
Start Saving Immediately!

Over 100,000 DENTAL Offices Nationwide!

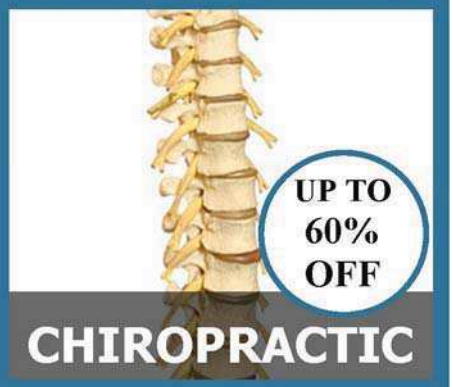
Enhanced Benefit Card
The EBC Card

Multi-Product Savings Program

No Paperwork.
No Claim Forms.
No Waiting Periods.



Dental Savings to 40% or more!



Dividend Club™

Save enough money each month while eating out to more than pay for your membership!

You may save thousands of dollars each year by shopping the hundreds of Dividend Club and Member eShop merchants as a VBA Member.

Printing & Shipping

VBA Membership also includes discounts on products and services at FedEx Office. **Enjoy a 30% discount on copy services** as well as a 10% discount on additional FedEx Office products and services.

Auto Rental Savings

AVIS offers VBA Members great money-saving coupons on top of special rates! Take advantage of year-round savings! **Alamo** offers year-round discounts on value-added promotions on leisure or business travel.

The Enhanced Benefits Card's discounts and savings are available to anyone—member or non-member.

DISCOUNT BENEFITS ARE NOT INSURANCE AND ARE NOT AVAILABLE IN ALL STATES

15575 North 79th Place, Suite 100, Scottsdale, Arizona 85260 (800) 366-2467

FORM ADH3-09 (02/2011)

Value Med Plan RATE$**

Rates stay as of Issue Age!

$1,000 Daily Hospital Benefit Option

ISSUE AGE	Monthly	Quarterly	Semi-Annual	Annual
18 — 39	$65.48	$190.57	$374.51	$735.78
40 — 44	$71.58	$208.31	$409.38	$804.28
45 — 49	$86.56	$251.89	$495.02	$972.53
50 — 54	$103.60	$301.48	$592.48	$1,164.01
55 — 59	$127.39	$370.72	$728.57	$1,431.37
60 — 64	$173.71	$505.53	$993.49	$1,951.84
*ALL CHILDREN COMBINED**	*$50.00*	*$145.51*	*$285.96*	*$561.80*

*Children issued $100 Daily Option only, regardless of Adult Benefit.

$500 Daily Hospital Benefit Option

ISSUE AGE	Monthly	Quarterly	Semi-Annual	Annual
18 — 39	$48.55	$141.28	$277.65	$545.49
40 — 44	$51.26	$149.17	$293.15	$575.94
45 — 49	$60.14	$175.00	$343.92	$675.68
50 — 54	$76.04	$221.29	$434.90	$854.42
55 — 59	$86.62	$252.07	$495.38	$973.24
60 — 64	$119.43	$347.55	$683.02	$1,341.89
*ALL CHILDREN COMBINED**	*$50.00*	*$145.51*	*$285.96*	*$561.80*

*Children issued $100 Daily Option only, regardless of Adult Benefit.

$100 Daily Hospital Benefit Option

ISSUE AGE	Monthly	Quarterly	Semi-Annual	Annual
18 — 44	$35.00	$101.85	$200.17	$393.26
45 — 49	$39.00	$113.49	$223.04	$438.20
50 — 59	$54.00	$157.15	$308.83	$606.74
60 — 64	$76.00	$221.17	$434.65	$853.93
*ALL CHILDREN COMBINED**	*$50.00*	*$145.51*	*$285.96*	*$561.80*

*Children issued $100 Daily Option only, regardless of Adult Benefit.

All Rates INCLUDE Office Calls & Outpatient Benefits!

Value Benefits of America
a Not-For-Profit Association

Add $5 monthly, $15 quarterly, $30 semi-annually, or $60 annually for **VBA Membership which INCLUDES ALL of the great benefits outlined in the brochure**

In states, where the Value Med Plan is issued as an individual/family policy, there is a $5 monthly, $15 quarterly, $30 semi-annual or $60 annual administrative fee per policy, not per individual.

**Rates shown are for all states, where Value Med is sold, except OR & SD

See the Bank Authorization Form for payment options, including List Bill.

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue, Glenview, Illinois 60025
(847) 699-0600

HOSPITAL CONFINEMENT INDEMNITY COVERAGE – THIS CERTIFICATE PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

OUTLINE OF COVERAGE

THIS IS NOT A MEDICARE SUPPLEMENT COVERAGE. If you are eligible for Medicare, review the `Guide to Health Insurance for People With Medicare' available from the company.

1. Read Your Certificate Carefully—This outline of coverage provides a very brief description of the important feature of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR CERTIFICATE CAREFULLY!

2. Hospital confinement indemnity coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.

3. Benefits – Your coverage under the group policy provides a daily benefit when you are confined to a hospital for a covered sickness or injury. This daily benefit will be paid from the first day of confinement and for each day you are confined for up to 365 days of confinement during your lifetime.

Daily Hospital Benefit …….. See Policy Schedule Page

4. **Exclusions and Limitations –** The policy will not cover loss resulting from pre-existing conditions during the first year that your policy is in force. A “pre-existing condition” is any sickness or injury diagnosed or for which medical advice and/or treatment was received from or recommended by a Physician within a twelve (12) month period prior to the effective date of your policy.

1. Your policy does not cover any sickness or injury which is the result of: (1) due to war or act of war whether declared or not; (2) intentionally self-inflicted injury; (3) mental illness or nervous disorders without demonstrable organic disease (loss due to Parkinson’s Disease, Alzheimer’s Disease or senile dementia is covered); (4 normal pregnancy and childbirth; complications of pregnancy, however, will be covered as a sickness; (5) treatment of an injury that results from your commission of, or attempt to commit a felony, or from you being engaged in an illegal activity; (6) cosmetic surgery; cosmetic surgery does not include reconstructive surgery which is incidental because of previous surgery due to trauma, infection, or other disease of the involved part; (7) confinement in a Hospital located or care received outside of the territorial limits of the United States of America, its commonwealth partners, or the countries of Canada and Mexico; or (8) you being intoxicated or under the influence of alcohol or a narcotic, unless administered on the advice of a Physician.

5. **Renewability –** Your coverage is Guaranteed Renewable to Age 65. This means that you may keep your coverage under the group policy in force until age 65 by paying the renewal premiums as they are due or during the 31-day grace period. Once you reach age 65 your coverage under the policy will terminate.

   We will have the right to change your renewal premium, but only if we change the table of premium rates for the group policy. If we make a change we will provide you with written notice at least thirty-one (31) days before any premium change is made.

GUARANTEE TRUST LIFE INSURANCE COMPANY

Glenview, Illinois

HOSPITAL CONFINEMENT INDEMNITY OUTLINE OF COVERAGE

6. **Additional Benefits** – In addition to the above Daily Hospital Benefit, the following benefits are also provided:

ADULT Doctor's Office Visit Benefit, per visit, maximum 1 visit per week $75.00

Maximum Doctor's Office Visits per Calendar Year 10

If the Optional Child Benefit Rider selected:

Child Doctor's Office Visit Benefit , per visit, maximum 1 visit per week $75.00

Maximum Doctor's Office Visits per Calendar Year for all Dependent Children 5

Outpatient Benefit Amount $100.00

Maximum Calendar Year Outpatient Benefit $200.00

Ambulance Benefit $200.00

REMEMBER, if you are not satisfied with your coverage, you have 10 days to return your certificate to us and get your money back.

FOR ADDITIONAL INFORMATION ABOUT BENEFITS OR CLAIMS, TELEPHONE US AT (847) 699-0600

.

If delivered at time of application by an agent:

Agent's Signature _____ Date of Delivery _____

Agent's Name (Printed) _____ Tony Novak

Phone/Fax: (800) 609-0683

Agent's Address and Phone No. _____

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue, Glenview, Illinois 60025

APPLICATION FOR HOSPITAL CONFINEMENT INDEMNITY COVERAGE UNDER POLICY FORM GP2005

POLICYHOLDER

Value Benefits of America, Inc.

APPLICANT INFORMATION

Person(s) Applying for Coverage	Age	Date of Birth	Sex	Height	Weight	Occupation	Social Security Number
Applicant (A):							
Spouse (S):							
Child 1 (C):							
Child 2 (C):							
Child 3 (C):							
Child 4 (C):							

Address: Phone:

Email:

BASIC BENEFITS INCLUDE

Hospital Benefit To 365 Days	Doctor's Per Visit Benefit	Outpatient Benefit	Ambulance
☐ $1,000 Daily, ☐ $500 Daily or ☐ $100 Daily	$75	$100	$200

ADDITIONAL BENEFITS

Child Rider

Yes ☐
$100 Daily Hospital Benefit to 365 Days

QUALIFYING MEDICAL QUESTIONS

1. Within the past 12 months has any person to be insured been confined to a hospital, nursing home or other medical facility or been disabled or been advised to have surgery but have not yet done so? ..... ☐Yes ☐ No
   If yes, indicate which person, condition, diagnosis, dates and types of treatment: _____

2. In the past 24 months has any person to be insured been diagnosed or treated by a medical professional for a heart condition, stroke, internal cancer or malignant melanoma, chronic obstructive lung disease, insulin dependent diabetes chronic liver or chronic kidney disease or drug or alcohol use? ..... ☐ Yes ☐ No
   If yes, indicate which person, condition, diagnosis, dates and types of treatment: _____

3. Has any person to be insured been medically diagnosed or receiving or been advised by a doctor to seek treatment for being HIV-positive or having AIDS or AIDS-Related Complex?..... ☐ Yes ☐ No
   If yes, indicate which person, condition, diagnosis, dates and types of treatment: _____

OTHER HEALTH COVERAGE

4. Please list all existing or pending coverage and indicate who is covered and if this coverage is to be replaced by this certificate. (Attach additional signed & dated sheet if more room needed.)

Who Covered?	Replacing?	Company Name	Type of Coverage
☐ A ☐ S ☐ C	☐ Yes ☐ No	_____	_____
☐ A ☐ S ☐ C	☐ Yes ☐ No	_____	_____

PREMIUM

Insurance Coverage $_____
Administrative Fee $_____
TOTAL PAYMENT DUE $_____

Please make check/money order payable to:
Guarantee Trust Life Insurance Company

Payment Mode: ☐ Annual ☐ Semi-Annual ☐ Monthly

Billing Method: ☐ Direct Bill ☐ Bank Draft ☐ List Bill

APPLICANT'S STATEMENTS

I HEREBY APPLY for coverage as indicated on this Application. I have read or had read to me the completed application. To the best of my knowledge and belief, the answers to the above questions are true and complete.

I UNDERSTAND AND AGREE that: (1) this coverage will be issued based solely and entirely upon my answers to the above questions; (2) no coverage will exist until a Certificate is issued, and will be in force only as of the Certificate effective date; (3) any misstatement of fact in this application may result in the denial of benefits or cause the Company to change or rescind my coverage; (4) any loss for a pre-existing condition will not be covered for the first 12 months my coverage is in force.

WARNING: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

Dated at _____ this _____ day of _____, 20_____

Signature of Applicant: _____

I certify that I have accurately recorded the information supplied by the Applicant. I further certify that 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.

Witness – Agent's Signature: _____

Agent's Name: _____ Tony Novak NAIC#2048780 _____ Agent's Number(s): _____

REQUIRED FOR ALL VALUE MED APPS

HIPAA AUTHORIZATION

This Authorization was prepared by for purposes of obtaining information necessary to underwrite my (our) application(s) for insurance.

Check Applicable Insurance Company

- ❑ **Guarantee Trust Life Insurance Company**
  125 Milwaukee Avenue, Glenview, IL 60025
- ❑ **United National Life Insurance Company of America**
  PO Box 7901, Mount Prospect, IL 60056

By signing this form, I (we) authorize the insurance company(ies) checked above (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 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 the Medical Information Bureau. 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. 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. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below.

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 the Company 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 Company's Underwriting Manager.

I (we) understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by the Company 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.

_____

(Print Please) Name of Applicant

_____

Signature of Applicant and Date

Bank Authorization, Payment Calculation, VBA Membership Enrollment

Required with ALL new Value Med Plan Applications

1 BANK DRAFT AUTHORIZATION AGREEMENT FOR AUTOMATIC MONTHLY PAYMENTS

I hereby authorize the indicated payee below to charge my account the insurance premiums and fees due monthly.

❑ **UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA (UNL)**
(Value Med Plan in AR, ID, IL, MO, NE, NV, NM, ND, OK, SD, TX, UT & WV)

❑ **GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL)**
(Value Med Plan in approved states not listed above)

I understand my account will be charged once each month for the total amount shown as due for my monthly premium and fees for the term of the policy of insurance issued to me. I understand that if a charge to my account is not honored, my insurance coverage could lapse. I further agree that you will not be under any liability for any dishonored electronic withdraws from my account, for any reason, even though the dishonor results in the forfeiture of benefits or membership. If any ACH item is dishonored, I authorize any additional returned check fees resulting from said dishonored check, to be charged to my bank account. I understand that if I wish to cancel my coverage, I must inform the named insurance company above of such cancellation within 30 days of the withdrawal date. Please charge my monthly premium and fees against the following account.

Name of Depositor, as it appears on the Bank Institution's Records

Account Number | Routing / Transit Number

Name of Banking Institution | Branch

Address | City | State | Zip

X _____
Authorized Signature | Date Signed

3 PAYMENT CALCULATION

MAKE CHECK PAYABLE TO THE AUTHORIZED PAYEE INDICATED FOR YOUR STATE LISTED ABOVE

❑ **Monthly Bank Draft** ❑ **Monthly List Bill*** ❑ **Quarterly** † ❑ **Semi-Annual** † ❑ **Annual** †

	Value Med Plan
	MAKE CHECK PAYABLE TO GTL or UNL
1. Applicant	$
2. Spouse	$
3. Child # of children x amount per child =	$
4. VBA Monthly Fees (VBA Classic Membership is required if not a current VBA Member)	$5.00
5. Monthly Admin Fee	N/A
6. **Total Monthly Due**†	**$**

* Minimum for Monthly List Bill is 5 on Value Med.

*** If you have purchased another level of VBA Membership, the $5.00 monthly dues are waived.
I have purchased another level of VBA Membership. ❑ **Yes** ❑ **No**

† For Quarterly, Semi Annual or Annual payment modes:
Quarterly, Semi-Annual – See brochure for rates (Add $30 VBA dues if not already a member.)
Annual - See brochure for rates. (Add $60 VBA dues if not already a member.)

VMP FORM 281 (Revised 12/10)

2 VBA MEMBERSHIP ENROLLMENT FORM

Print Primary Member Name: _____

I agree to the Value Benefits of America terms and conditions as listed on this form.

X _____
Signature of Primary Member | Date Signed

About Value Benefits of America Classic Membership: Classic Benefits include over 400 major chains on-line in over 50 shopping categories, including everything from major department stores to specialty retailers to boutiques. In addition to earning rewards up to 25% shopping at participating on-line merchants, you can also receive point of sale discounts up to 50% from leading national retailers. Point-of-sale discounts are available on brand name merchandise, travel services and entertainment, including savings on movie tickets, movie rentals and at theme parks nationwide. You'll also enjoy savings of up to 60% dining at fine restaurants nationwide with discounted dining certificates, and the savings don't stop there. Included at no charge are discounts at over 55,000 pharmacies for your prescription drugs as well as lab tests and x-ray imaging services. Complete details of membership benefits are provided at www.VBAmembers.com.

VBA Terms & Conditions

1. Member understands that VBA is not an insurance company or program. Insured Benefit Payments are made by the administrator for the insurance company issuing the blanket coverage to Members.
2. VBA provides savings to its members on services through a number of sources. The current list of benefits may be modified through additions or deletions. A quarterly newsletter, posted on our website or sent via e-mail, will keep Members up to date on benefits and other pertinent information.
3. Payments for the VBA Program are due in advance. Payments will be drafted on or about 15 days before the due date. If you choose to cancel your program, it is your responsibility to make sure that your membership card and a written request for cancellation are sent to VBA at least 15 days prior to the anniversary of your effective date in order for your account not to be charged for additional fees.
4. Member hereby appoints, Value Benefits of America Association (VBA) President, or failing this person, a VBA Director, as proxy holder for and on behalf of the member with the power of substitution to attend, act and vote for and on behalf of the member in respect of all matters that may properly come before the meeting of the members of VBA and at every adjournment thereof, to the same extent and with the same powers as if the undersigned member were present at the said meeting, or any adjournment thereof. Annual meetings are to be held in Arizona the second Tuesday of August.
5. VBA reserves the right to terminate any enrollment or deny eligibility in the program for lack of payment to VBA. Returned checks, insufficient notices on bank drafts, or denial by the member's credit card company for payment of the membership fee is deemed to be evidence of non-payment by a member. There will be a $10.00 charge to be reinstated in the program after such denial. If reinstatement for non-payment happens more than once, a $20.00 reinstatement will apply.
6. In the event of any dispute, member agrees to resolve said dispute solely by binding arbitration that shall be governed by the laws of the state of Arizona and enforceable at Scottsdale, Maricopa County.
7. Membership cancelled within the first 30 days of the enrollment date may be eligible for refund if the membership card and written cancellation request are sent to VBA. The administrative fee is not refundable. Approved refunds will be processed approximately 30 days after cancellation.
8. Membership is effective on the 1st of the month following enrollment acceptance by VBA.

Member Agreement: By signing the enrollment form, Member expresses desire to become a member of Value Benefits of America. Member acknowledges that the discount plans ARE NOT INSURANCE, but membership may include certain limited supplemental insured coverage's. Membership benefits are not a replacement for health insurance coverage nor are they intended as a substitute for health insurance coverage. Membership fees may be changed for all members in that class but not individually, with notification.

Please mail completed forms and your check(s) to:

VALUE BENEFITS OF AMERICA
15575 N. 79TH PL. #100
SCOTTSDALE, AZ 85260

Tony Novak NAIC#2048780

Marketed By | GAC #

GUARANTEE TRUST LIFE INSURANCE COMPANY

Glenview, Illinois

NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by The Guarantee Trust Life Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

(1.) Health conditions which you may presently have (pre-existing) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.

(2.) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.

(3.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/ health history. Failure to include all material medical information on any application may provide basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

(4.) Even though some of your present health conditions may be covered under the new policy these conditions may be subject to certain waiting periods under the new policy before coverage is efficient.

The above "Notice to Applicant" was delivered to me on _____
Date

_____
Applicant's Signature

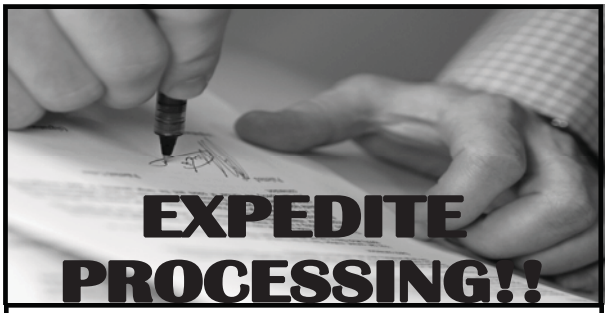
HRF-8.1

White Applicant's Copy - Yellow Home Office Copy

REQUIREMENTS FOR NEW BUSINESS SUBMISSION

All products, brochures, applications and forms can be found at:
www.gacquote.com

Please be sure you are using the most up-to-date materials!
CALL US if you have questions! 800-366-2467



In order to process applications quickly and accurately, please review all applications prior to submission.

BE THOROUGH & SAVE TIME!

Incomplete, inaccurate and/or illegible applications cause delays in processing.

HAVE YOU . . . ✓

⇒ **Completed** ALL required forms?

⇒ **PRINTED** all information legibly?

⇒ **SIGNED** all forms?

⇒ **Provided** a client check made payable to OR a voided check?

⇒ **Matched** the premiums & fees on the Bank Authorization form to the premiums listed on the application?

Value Med Plan

- ❑ Replacement Form*
- ❑ GTL or UNL Application (state specific)
- ❑ GTL/UNL HIPPA Form
- ❑ Arbitration Form (Alabama Only)
- ❑ Bank Authorization Form (only ONE per client)
- ❑ Payable Check OR Voided Check

*Replacement Form is required for Value Med Plans if replacing insurance in the following states:

AR, CO, DE, FL, ID, IL, IA, KY, OK, PA, SC, TX, UT, VA, WI, WV

VBA & AHIR & NEA ACCIDENT PLANS

Replacement Form Not Required

- ❑ Enrollment Form
- ❑ Payment Authorization (& Voided Check if applicable)

VALUE MED PLAN AGENT GUIDELINES

Underwritten by United National Life Insurance Company of America (UNL) in AR, AZ, ID, IL, MO, NE, NV, NM, OK, SD, TN, TX, UT & WV)
Underwritten by Guarantee Trust Life Insurance Company (GTL) In all other approved states

1. ISSUE DATE: Business is issued on the date approved in underwriting by the carrier (usually in 10 days). You can request a later effective date with a note attached to the application. If no money is received the carrier may need up to 15 days.
2. MONIES COLLECTED: Make checks payable to the insurance company. Applicants can pay by Monthly Bank Draft, Semi-Annual, Annual or Monthly List Bill. Make sure the applicant is aware that their account will be drafted immediately if they did not submit money and thereafter (after issuance) approximately 15 days prior to the due date. The insurance company processes the monthly collections for individuals on the Value Med. (List bill instructions are in #6 below).
3. ORIGINAL APPLICATION(S) ARE PREFERRED: We do accept legible fax/photo copies. If not legible, issue is delayed for the individual.
4. MUST INCLUDE THESE SIGNED FORMS: HIPAA Authorization, VBA membership enrollment and an Automatic Monthly Bank Draft (and voided check).
5. CONTACT INFORMATION: Most correspondence regarding application is sent to the agent via email, phone or mail. We may be required to call on the customer, so always include the email address, if available and the phone number.
6. LIST BILL: No group participation and a minimum of 5 or more employees must apply. The 1st month's premium and fees must be paid to issue on a List Bill. Please use the GTL/UNL List Bill Form and make check payable to either GTL or UNL.
7. COMMISSION PAYMENT: New business will be paid weekly upon issue and renewals on or about the 20th of each month.
8. CHANGES AND CANCELLATIONS: Any changes, including cancellations must be in writing and sent to GAC or the insurance carrier.
9. FULFILLMENT: All fulfillment information, Certificate of Insurance and ID cards will be mailed directly to your client.
10. CHILD COVERAGE: Children may be covered by including them on the application. Child(ren) only coverage is not available.
11. COVERAGE REPLACEMENT: GTL/UNL requires a signed Replacement Form in the states of: AR, CO, DE, FL, IA, ID, IL, KY, OK, PA, SC, TX, UT, VA, WI & WV. Also list the reason coverage is being replaced.
12. OUTLINE OF COVERAGE: Some states have an outline of coverage form: AR, ID, OK, OR, SC, UT & WV

FEMALE			MALE		
Height	Min Weight	Max Weight	Height	Min Weight	Max Weight
4'8"	77	212	5'0"	91	234
4'9"	78	216	5'1"	93	237
4'10"	79	220	5'2"	95	243
4'11"	81	224	5'3"	98	247
5'0"	83	229	5'4"	101	256
5'1"	85	238	5'5"	103	262
5'2"	87	243	5'6"	106	270
5'3"	89	244	5'7"	109	276
5'4"	91	250	5'8"	112	286
5'5"	93	256	5'9"	115	296
5'6"	96	262	5'10"	118	299
5'7"	98	268	5'11"	121	308
5'8"	101	274	6'0"	124	312
5'9"	104	287	6'1"	127	323
5'10"	107	288	6'2"	131	328
5'11"	110	296	6'3"	134	339
6'0"	114	305	6'4"	138	360
6'1"	117	314	6'5"	142	385
6'2"	120	323	6'6"	146	409
			6'7"	150	418
			6'8"	154	427

UNDERWRITING GUIDELINES

The applicant and spouse height and weight must be within the guidelines listed on the chart.

APPLICATION QUESTION 1:
If "Yes", provide details. If the hospitalization or other confinement was due to a fracture or minor surgery (gall bladder, appendix or child birth) the applicant can qualify. If for a major surgery, or hospitalizations or other confinements due to a major illness or sickness, the applicant will not be eligible for the plan.

APPLICATION QUESTIONS 2 & 3:
If "Yes" is answered for either question, the applicant will not be eligible for the coverage.

THERE ARE NO RATE UPS AND NO ELIMINATIONS!
Underwriting decisions are made based on the information disclosed on the application for insurance. Any false or incomplete information listed on the application can result in a rescission within the first 2 years of coverage.

PRE-EXISTING CONDITION LIMITATION:
Pre-existing conditions are those medical conditions disclosed or not disclosed on the application which were diagnosed or for which medical advice or treatment was recommended or received from a Doctor within a 12 month period (6 months in ID) immediately preceding the Effective Date of a Covered Person's coverage. Any loss due to a pre-existing condition is not covered unless the loss begins more than 12 months after the Effective Date of a Covered Person's coverage.

General Agent Center

15575 N. 79th Place #100, Scottsdale, AZ 85260
Phone 1-800-366-2467 Fax 1800-471-7996
Email: newsales@gacquote.com