APPLICATION FOR LIMITED BENEFIT POLICY

GUARANTEE TRUST LIFE INSURANCE COMPANY

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

Application for: ☐ **New Coverage** ☐ **Reinstatement** ☐ **Increase of Benefits**

If Reinstatement or Increase requested, please print GTL policy/certificate number(s) affected:_____

MAIL POLICY TO: ☐ **Agent** ☐ **Insured**

PART A. APPLICANT(S) INFORMATION

APPL #1	Last Name _____ First Name _____ M.I ___ Birth Date_____ Soc. Sec. # _____ Sex _____ Age _____
APPL #2	Last Name _____ First Name _____ M.I ___ Birth Date_____ Soc. Sec. # _____ Sex _____ Age _____
ADDRESS	Street Address _____ City _____ State _____ Zip Code _____ Telephone (Day) _____ E-Mail Address _____

IF YOU ARE 6 MONTHS YOUNGER OR OLDER THAN 65, AS OF THE DATE OF THIS APPLICATION SKIP TO SECTION B.

QUALIFYING INFORMATION (If any answer to questions 1 thru 5 is "YES" you are not eligible for coverage.)

	Applicant #1	**Applicant # 2**
SECTION A.		
1. In the past 12 months have you been confined as an inpatient to a hospital, nursing home or have you received home health care?	☐YES ☐NO	☐YES ☐ NO
2. In the past 12 months have you had known symptoms or known indications for a heart attack, stroke, heart surgery/bypass, malignant melanoma or cancer (other than skin cancer)?	☐YES ☐NO	☐YES ☐ NO
3. In the past 12 months have you been treated for chronic obstructive lung disease, insulin dependent diabetes, dementias, Alzheimer's disease, congestive heart failure, or chronic liver or kidney disease?	☐YES ☐NO	☐YES ☐ NO
4. In the past 12 months have you had surgery which required an inpatient hospital stay or been advised by a medical practitioner to have surgery which will require an inpatient stay but have not yet done so?	☐YES ☐NO	☐YES ☐ NO
5. In the past 7 years have you ever been treated for or been diagnosed by a member of the medical profession as having Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC) or HIV infection?	☐YES ☐NO	☐YES ☐ NO
SECTION B. (To be completed if choosing the Lump Sum Cancer Rider; if question 6 or 7 is answered "YES" you are not eligible for the Lump Sum Cancer Rider.)		
6. In the past 7 years, have you had known symptoms or known indications for, been diagnosed as having, received medication for, or been treated by a medical practitioner for leukemia, Hodgkin's or Non-Hodgkin's disease, malignant melanoma, sarcoma or any other internal cancer or had radiation or chemotherapy for any of these conditions?	☐YES ☐NO	☐YES ☐ NO
7. In the past 24 months, have you been advised by a medical practitioner to seek treatment or medical advice from a medical practitioner, or had experienced any known symptoms that would have caused an ordinarily prudent person to seek medical advice for any of the medical conditions listed in question #6?	☐YES ☐NO	☐YES ☐ NO
SECTION C.		
8. Will this policy replace any existing insurance with any company? If "YES", what company, type(s) of insurance and policy number(s) _____ _____	☐YES ☐NO	☐YES ☐ NO

PART B. COVERAGE SELECTION ***Complete appropriate section for each plan selected***

Daily Hospital Confinement Benefit • Choose an amount from $100 - $600 (in $10 increments) • Choose Number of Days Payable Per Benefit Period	**Applicant #1** $_____ per day ☐ 10 Days ☐ 21 Days	**Applicant #2** $_____ per day ☐ 10 Days ☐ 21 Days
Optional Riders: Lump Sum Hospital Benefit: Choose 1 of 3 Benefit Amounts	☐ $250 ☐ $500 ☐ $750	☐ $250 ☐ $500 ☐ $750
Ambulance Service Benefit (maximum age – 80)	☐	☐
Skilled Nursing Facility Benefit	☐	☐
Accidental Death and Dismemberment (maximum age – 80) • Choose Benefit Level • Choose Beneficiary	☐ $10,000 ☐ $5,000 _____ _____ Beneficiary and Relationship	☐ $10,000 ☐ $5,000 _____ _____ Beneficiary and Relationship
Lump Sum Cancer Rider: Choose 1 of 4 Benefit Amounts	☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000	☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000
Surgical Benefit Rider: Choose 1 of 4 Benefit Amounts	☐ $250 ☐ $500 ☐ $750 ☐ $1000	☐ $250 ☐ $500 ☐ $750 ☐ $1000

PART C. PREMIUMS

	Applicant #1	**Applicant #1**
Daily Hospital Indemnity Annual Premium	$_____	$_____
Optional Rider Annual Premium		
Lump Sum Hospital Benefit:	$_____	$_____
Ambulance Service Benefit:	$_____	$_____
Skilled Nursing Facility Benefit:	$_____	$_____
Accidental Death & Dismemberment Benefit:	$_____	$_____
Lump Sum Cancer:	$_____	$_____
Surgical Benefit:	$_____	$_____
Total Annual Premium:	$_____	$_____

Premium Payment Mode: ☐ Annual ☐ Semi-Annual (.520) ☐ Quarterly (.265) ☐ Monthly PAC (.084)

	Applicant #1	**Applicant #2**
Total Mode Premium for Applicants #1 and #2	$_____	$_____

Application Fee (if applicable):	$_____
Total submitted Premium:	$_____

Requested Effective Date: ___/___ /____
Requested Effective Date cannot be prior to the Application Date. If no Effective Date is requested, the Effective Date will be the date of the underwriting decision to approve issuance coverage.

ACKNOWLEDGEMENTS & AUTHORIZATION

ALL STATEMENTS I HAVE MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I UNDERSTAND THAT OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR RESCISSION, VOIDING, OR REFORMATION OF INSURANCE.

I understand that insurance applied for will not become effective until: a) approved and issued by GTL; b) I have been furnished written notice of the effective date; and c) I have paid the premium in full. I understand that any changes in my health conditions, if applicable, from the date of this application until insurance becomes effective, may result in the declination of my coverage. No agent or other representative of GTL has required, permitted, or encouraged me to answer any question inaccurately or has waived any conditions of this application. I 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 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 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 physical condition, other coverage and any other information needed to underwrite my 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. This Authorization includes all information about drugs, alcoholism, and mental illness. I 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 agree that this Authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it.

I have received an Outline of Coverage. If this application is completed electronically, I 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 understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I 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 agent or to the attention of the Underwriting Manager.

I 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 also understand that my application for insurance can be declined if I choose not to sign this Authorization.

Any person who knowingly or willfully presents a false or fraudulent claim for payment of a loss or benefit or who knowingly or willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

Signed at: _____

Date City and State

_____

Applicant #1 Signature Applicant #2 Signature (if applicable)

AGENT'S STATEMENT

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 the applicant is notified in writing by Guarantee Trust Life Insurance Company. I certify that I asked all the questions and truthfully and accurately recorded the answers contained herein (except if application is completed electronically or over the phone).

To the best of my knowledge and belief, the insurance applied for: ☐ is or is likely or ☐ is not or is not likely to replace or change any existing policy(ies) or contract(s).

_____

Agent's Name (Printed) Agent Code

_____

Agent's Signature Date

_____

Agent's E-mail Address

APPH1-07-MD(Rev.1-13)

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 is 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

---

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
1275 Milwaukee Avenue, Glenview, Illinois 60025

SUPPLEMENT TO APPLICATION

Applicant Name: _____
Please Print

Required only if Applicant's spouse is applying for coverage. Spouse includes legally married/common law spouse and civil union/domestic partner, if legally recognized in the Applicant's State.

Spouse Name: _____
Please Print

IMPORTANT DISCLOSURE STATEMENT

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.

* *Minimum Essential Coverage is the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.*

INDIVIDUAL ATTESTATION REGARDING MINIMUM ESSENTIAL COVERAGE

I hereby attest that I am covered by a major medical policy or other medical health insurance that qualifies as "minimum essential coverage" under the Affordable Care Act.

_____ _____
Applicant Signature *Date*

_____ _____
Signature of Spouse (if also applying for coverage) *Date*

GUARANTEE TRUST LIFE INSURANCE COMPANY
Electronic Delivery and Communications Disclosure and Consent

Consent and Acknowledgement
By signing below, you (and any co-applicants) give us consent to provide you, in electronic format, the following documents that form our insurance relationship:

- Application(s) and related forms
- Policy or certificate insurance fulfillment documents
- Disclosures, where required by state and / or federal law

With this Consent, you acknowledge that you:

1. Are able to view, save and print PDF files (such as Adobe® Reader® 5.0 or higher.)
2. Will provide and maintain a valid designated e-mail address. (We reserve the right to validate the email address you provide us.)

Access to Paper Copies
To ensure you have them when you need them, you should print copies of the documents we send through Electronic Communication. However, you may request from us one paper copy of your policy / certificate fulfillment package free of charge. Except where prohibited by law, we may charge a nominal fee for additional copies requested after the first. You may contact us with your request in writing, by phone, or email as indicated in our Company Contact Information, shown below.

Our Right to Send Paper
We reserve the right to provide paper copies in lieu of Electronic Communication even if you have provided us with your Consent to Electronic Communication. We would do this in the event of, but not limited to, a system outage, if we suspect fraud, or where the designated email address you have provided to us does not accept emails from us.

Changes to the Terms and Conditions of Electronic Communication
At our discretion, we reserve the right to modify the terms and conditions stated herein. This includes modifying the terms to include additional instances for Electronic Communication other than policy or certificate fulfillment. If we do, we will provide you with notice of such change, its effective date electronically and your choices under the new terms and conditions.

Withdrawal of Consent
You may elect to withdraw your Consent for Electronic Delivery and Communications at any time by contacting us in writing, by phone, or through the Customer Service link on our website. Please see 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 Policyholder tab at the top of the screen. Choose "Customer Service" from the list of options to communicate with us.

_____ _____
Applicant Signature *Date*

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025

SUPPLEMENT TO APPLICATION

Applicant Name: _____
Please Print

Required only if Applicant's spouse is applying for coverage. Spouse includes legally married/common law spouse and civil union/domestic partner, if legally recognized in the Applicant's State.

Spouse Name: _____
Please Print

IMPORTANT DISCLOSURE STATEMENT

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.

* *Minimum Essential Coverage is the type of coverage an individual needs to have to meet the individual responsibility requirement under the Affordable Care Act. This includes individual market policies, job-based coverage, Medicare, Medicaid, CHIP, TRICARE and certain other coverage.*

INDIVIDUAL ATTESTATION REGARDING MINIMUM ESSENTIAL COVERAGE

I hereby attest that I am covered by a major medical policy or other medical health insurance that qualifies as "minimum essential coverage" under the Affordable Care Act.

_____ _____
Applicant Signature *Date*

_____ _____
Signature of Spouse (if also applying for coverage) *Date*

GUARANTEE TRUST LIFE INSURANCE COMPANY
A Mutual Company
1275 Milwaukee Avenue, Glenview, Illinois 60025
(847) 699-0600

HOSPITAL CONFINEMENT BENEFIT POLICY

Guaranteed Renewable for Life
Premiums May Be Changed By Class

OUTLINE OF COVERAGE

For Policy Form G0553-MD
With Optional Rider Forms RG05SNF-MD, RG05LSH-MD, RG05ASB-MD, RG05ADD-MD, RG07LS-MD, and RG07OPS-MD

KEEP THIS OUTLINE FOR YOUR RECORDS

THIS IS NOT A MEDICARE SUPPLEMENT POLICY

THIS IS A LIMITED BENEFIT POLICY - READ YOUR POLICY CAREFULLY – This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. Your policy sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you READ YOUR POLICY CAREFULLY!

LIMITED BENEFIT COVERAGE – This policy is designed to provide, to persons insured, Limited Benefit 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. Such policies do not provide any benefits other than the fixed daily benefit for hospital confinement and any additional benefits described below.

BENEFITS

We will only pay benefits for Hospital Confinements, Emergency Room Services, and Mental Health Hospital Confinements that are Medically Necessary and begin while the Policy is in force.

BENEFIT A : HOSPITAL CONFINEMENT BENEFIT (INJURY OR SICKNESS)

We will pay the Hospital Confinement Indemnity Benefit Amount shown on the Policy Schedule, for each day You are Hospital Confined due to Injury or Sickness. Benefits are subject to the Maximum Benefit Period, as shown in the Policy Schedule, for any One Period of Confinement as defined in the Policy.

Hospital Confinement Benefit selected: $_____ per day

Maximum Benefit Period selected: ☐ 10 days ☐ 21 days

BENEFIT B: MENTAL HEALTH BENEFIT

We will pay the Mental Health Benefit Amount, shown in the Policy Schedule, for each day You are Hospital Confined due to a Mental or Nervous Disorder. This benefit is subject to the maximum number of days payable as shown in the Policy Schedule.

BENEFIT C: EMERGENCY ROOM BENEFIT (INJURY ONLY)

We will pay the Emergency Room Benefit shown in the Policy Schedule for services in a Hospital emergency room or Hospital affiliated emergency care facility for loss due to Injury, provided the Emergency treatment is followed within 24 hours by a covered Hospital Confinement of at least one day. This benefit is payable only once per any One Period of Confinement.

We won't pay benefits under both Benefit A and Benefit B above for the same day of Hospital Confinement.

LIMITATIONS AND EXCLUSIONS:

PRE-EXISTING CONDITION LIMITATION

Pre-existing Condition: A Sickness or Injury, disclosed or not disclosed on the application, for which medical care, treatment, diagnosis or advice was received or recommended within the 6 month period immediately prior to Your Effective Date of coverage under this Policy; or the existence of symptoms which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 6 months prior to Your Effective Date of coverage under this Policy. Treatment includes the taking of Prescription Drugs or medicines.

Pre-existing conditions are not covered unless the loss begins more than 6 months after Your Effective Date of coverage.

A Pre-existing Condition does not include a condition admitted in the application, which was not excluded by a signed waiver rider.

EXCLUSIONS

We won't pay benefits for:

1. Treatment, services or supplies which:
   - Are not Medically Necessary;
   - Are not prescribed by a Doctor as necessary to treat an Sickness or Injury;
   - Are determined to be Experimental/Investigational in nature by Us;
   - Are received without charge or legal obligation to pay, except treatment, services or supplies paid by the Department of Health and Mental Hygiene;
   - Would not routinely be paid in the absence of insurance;
   - Are received from any Family Member.
   - Are received outside the United States.
2. Expenses incurred as a result of loss due to war, or any action of war, declared or undeclared; service in the armed forces of any country.
3. Expenses incurred as a result of suicide or intentionally self-inflicted Injury while sane or insane.
4. Injury or Sickness arising out of or in the course of employment or which is compensable under any Workers' Compensation or Occupational Disease Act or Law.
5. Cosmetic surgery other than:
   - Reconstructive surgery incidental to or following surgery resulting from trauma, infection, or other diseases of the involved part; or
   - Reconstructive surgery because of a congenital disease or anomaly.

OPTIONAL COVERAGE(S): (Available for an additional premium)

Skilled Nursing Facility Benefit Rider RG05SNF-MD
We will pay the Skilled Nursing Benefit Amount as shown in the Policy Schedule, for each day You are confined in a Skilled Nursing Facility provided that;

1. You have first been Hospital Confined for 3 or more consecutive days;
2. The Skilled Nursing Facility confinement begins within 30 days after such Hospital Confinement;
3. Your Doctor must certify the need for the Skilled Nursing Facility confinement; and
4. The Skilled Nursing Facility confinement is for the same Injury or Sickness as the Hospital Confinement for which We paid benefits.

The Skilled Nursing Facility Benefit Amount is subject to the Elimination Period and payable only for those days indicated in the Policy Schedule under Skilled Nursing Maximum Benefit Period. We will not pay more than the number of days indicated in the Skilled Nursing Maximum Benefit Period for any One Period of Confinement as defined in the Policy.

Lump Sum Hospital Benefit Rider RG05LSH-MD
We will pay the Lump Sum Hospital Benefit Amount when You are Hospital Confined. Lump Sum Hospital Benefits are payable only;

1. When the Hospital Confinement is covered under the Policy to which this Rider is attached; and
2. Once during any One Period of Confinement.

Lump Sum Hospital Benefit Amount Selected: □ $250 □ $500 □ $750

Ambulance Service Benefit Rider RG05ASB-MD
We will pay the Ambulance Service Benefit Amount, shown on the Schedule, if a licensed surface ambulance service transports you to or from a Hospital to which you are Hospital Confined. This Benefit is payable no more than once per Hospital Confinement for all trips. The Hospital Confinement requiring the ambulance service must be Medically Necessary and covered by the Policy. We will not pay more than the Lifetime Maximum Amount shown on the Policy Schedule.

Accidental Death and Dismemberment Benefit Rider RG05ADD-MD
ACCIDENTAL DEATH BENEFIT
We will pay the Loss of Life Benefit, shown on the Schedule, to the Beneficiary named in the application (or as later changed) if you die solely as a result of Injuries. Our payment will be subject to all of the provisions of the Policy and this Rider.

DISMEMBERMENT BENEFIT
We will pay the appropriate Dismemberment Benefit, listed on the Schedule, to you if you suffer total and irrecoverable loss of eyesight or limbs solely as the result of an Injury.

Loss means with regard to hands and feet, dismemberment by severance through or above the wrist or ankle joint; with regard to eyes, the loss of sight must be total and irrecoverable, and beyond remedy by surgical or other means.

If more than one Loss is sustained as a result of one Accident, We will pay only one amount, the largest to which You are entitled.

Accidental Death and Dismemberment Benefit Rider Exclusions
These exclusions are in addition to the Exclusions in the Policy. No benefits are payable for any loss caused by:

1. Bodily or mental infirmity.
2. Bacterial infections except:
   Infections which occur simultaneously with or through a cut or wound sustained as the direct result of an Injury, independent of any other cause; and
   The accidental ingestion of a contaminated substance.

3. Any kind of disease or hernia.
4. Medical or surgical treatment, except losses that result directly from surgical operations made necessary solely by Injury which is the direct result of an Accident, independent of disease or bodily infirmity or any other cause, and performed within 3 months of the Accident.
5. Travel, or flight in or descent from any kind of aircraft unless:
   a.) As a fare paying passenger on a regularly scheduled flight.
   b.) As a passenger on an official flight of the Military Airlift Command of the United States or similar air transport services of other countries.
6. Any accident or occurrence arising out of or in the course of employment.
7. Sickness or its medical or surgical treatment, including diagnosis.
8. Voluntary gas inhalation or poison voluntarily taken, administered or inhaled.
9. Riding or driving as a professional in any kind of race for prize money or profit.
10. Any loss where the contributing cause was the insured's commission of or attempt to commit a crime.
11. Any loss sustained or contracted in consequence of being intoxicated or under the influence of any narcotic unless administered on the advice of a Doctor.

This Rider will terminate on the earliest of:
a. The date the Policy to which this Rider is attached is terminated;
b. The date you ask us, in writing, to cancel this Rider;
c. The date the Policy lapses for non-payment of premium; or
d. The first monthly anniversary that occurs on or after your 85th birthday.

Accidental Death And Dismemberment Benefit Selected: ☐ $5,000 ☐ $10,000

Lump Sum Cancer Rider RG07LS-MD
We will pay the Lump Sum Benefit Amount provided You have:
1. met the conditions set forth in the Eligibility for Benefits provision of this Rider, and
2. satisfied this Rider's Proof of Loss provision.

The Lump Sum Benefit Amount is shown in the Policy Schedule.
Benefits under this Rider are limited to one (1) Lump Sum payment during Your lifetime.

Lump Sum Cancer Rider Amount Selected: ☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000

Surgical Benefit Rider RG07OPS-MD
We will pay the Surgical Benefit Amount for a surgical procedure performed by a doctor when such procedure is performed in an Ambulatory Surgical Center or Outpatient Facility of a Hospital. Surgical procedures and the services and supplies related to the surgical procedures are limited to two occurrences per calendar year not to exceed the Maximum Surgical Benefit Amount shown in the Policy Schedule.

Surgical Benefit Rider Exclusions

The following rider exclusions are in addition to the exclusions contained in the Policy to which this Rider is attached. We won't pay benefits for:
1. Surgical procedures performed in a Doctor's office or when Hospital Confined;
2. Surgery for corns, calluses and bunions; deviated nasal septum, including submucous resection and/or other surgical corrections thereof unless due to injury occurring while coverage is in force;
3. Surgery for removal of breast implants. This exclusion shall not apply to the removal of breast implants for the medically necessary treatment of a covered illness or injury, unless the implants were implanted solely for cosmetic purposes and not for surgery performed as reconstruction resulting from an illness or injury.
4. Surgery for non-malignant warts, moles (boils) and lesions unless Medically Necessary;
5. Surgery for sex transformation or reversal thereof
6. Dental surgery except oral surgery for excision of tumors, growths and cysts of the jaw and mouth and surgery to sound natural teeth made necessary by injury.

7. Surgery for refractive anomalies.

Surgical Benefit Rider Amount Selected: □ $250 □ $500 □ $750 □ $1,000

GUARANTEED RENEWABLE FOR LIFE You may keep this Policy, and Riders if attached, in force during Your entire lifetime, unless otherwise stated in the Rider, by paying the renewal premium at the intervals available to You at time of renewal. You must pay the renewal premium by its due date or during the 31 days that follow. We cannot cancel or refuse to renew this Policy or place any restrictions on it if You pay Your premiums on time.

PREMIUMS SUBJECT TO CHANGE We may change the premium rates for this Policy/Riders by giving You at least 40 days prior written notice of any change in the renewal premium. We can only change the premium if We change it for all Policies/Riders like Yours in Your state on a class basis.

INITIAL PREMIUM:
Limited Benefit Hospital Policy: $_____

□ **Skilled Nursing Facility Benefit Rider: $_____**
□ **Lump Sum Hospital Benefit Rider: $_____**
□ **Ambulance Service Benefit Rider: $_____**
□ **Accidental Death and Dismemberment Rider: $_____**
□ **Lump Sum Cancer Rider: $_____**
□ **Surgical Benefit Rider: $_____**

TOTAL PREMIUM: $_____

GUARANTEE TRUST LIFE INSURANCE COMPANY

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you the different ways in which Guarantee Trust Life Insurance Company ("GTL") may use and disclose your protected health information.

Among other things, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") requires us to:

- Maintain the privacy of your protected health information.
- Provide notice of GTL's legal duties and privacy practices with respect to your protected health information.
- Comply with the terms of the Notice currently in effect; and
- Provide you with this Notice.

You have a right to a paper copy of this Notice which will be provided to you upon request, even if this Notice was provided to you electronically.

Protected health information is information about you that is either held or transmitted by GTL, including demographic information, that identifies you (or can reasonably be used to identify you), and that relates to (i) your past, present or future physical or mental health or condition, (ii) the provision of health care to you, or (iii) the past, present or future payment for the provision of health care to you.

GTL understands that your protected health information is personal. We protect the privacy of that information in accordance with all federal and state privacy laws. If a use or disclosure of protected health information described within this Notice, which is required by federal law, is prohibited or materially restricted by state law, GTL will abide by the more stringent law.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITH YOUR WRITTEN AUTHORIZATION

GTL will not use or disclose your protected health information without your written authorization unless the use or disclosure is described within this Notice.

If you have given us written authorization to use or disclose your protected health information, you have the right to revoke that authorization, at any time, except to the extent that: (1) we have already acted in reliance on the authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides us with the right to contest a claim under the policy or the policy itself. Your written request to revoke an authorization should be directed to the address listed in the "Contact Information" section below.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

For Payment

We may request, use and disclose your protected health information, as needed, to determine or fulfill our responsibility for coverage and reimbursement for the provision of benefits under your health plan. This may include, but is not limited to:

- determinations of eligibility of coverage (including coordination of benefits with other insurers or the determination of cost sharing amounts) and adjudication or subrogation of health benefit claims;
- risk adjusting based on enrollee health status and demographic characteristics;
- billing, claims management, collection activities, obtaining payment under a contract for reinsurance;
- review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;
- utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services;

- disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: name and address; date of birth; social security number; payment history; policy/account number; and name and address of the health care provider and /or health plan.

For example, if your coverage has a coordination of benefits or other type of cost sharing provision, we may request and disclose protected health information about you to the other health plan carrier to determine the benefits due under the terms of your health plan with us. We may also contact your provider regarding your medical treatments and request details to determine if your coverage will pay for the treatments.

For Health Care Operations

We may use and disclose protected health information about you to support our business operations or the business operations of another insurer. These uses and disclosures are necessary to run the company and make sure all of our policyholders receive the services and benefits provided by their health plan coverage. These activities include, but are not limited to:

- underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, however, we are prohibited from using or disclosing genetic information about you for underwriting purposes;
- ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services, and auditing functions, including fraud investigations;
- business planning and development, such as conducting cost-management studies and analyses related to managing and operating the company, including development or improvement of methods of payment or coverage policies; and
- business management and general administrative activities of the company, including, but not limited to:
  - customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
  - resolution of internal grievances; and
  - the offer of an enhancement or upgrade to your existing coverage.

To Individuals Involved in Your Care

We may use and disclose your protected health information with your family, friends, personal representative or other individual you identify who are involved in your care or payment of a claim, unless you object. In addition, GTL may use and disclose your protected heath information to persons requesting such information if we can reasonably infer from the circumstances that you would not object to the disclosure. If you are not available to give your consent to a disclosure, or in an emergency, we may disclose your protected health information that is directly relevant to such person's involvement in your care or payment for such care.

To Our Business Associates

We may also share your protected health information to an affiliate or business associate outside of GTL if they need protected health information in order to provide services to us (e.g., billing, claim adjudication and underwriting services.) Whenever an arrangement between GTL and a business associate involves the use or disclosure of your protected health information we will have a written contract that sets forth the terms regarding the use and disclosure of your protected health information and will require them to follow the HIPAA rules relating to the protection of protected health information.

For Other Uses and Disclosures

In addition to the above, we are permitted or required by law to use or disclose your protected health information, without your permission, for the following:

- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order. We may disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement:** We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process. We may also disclose your protected health information if we suspect child abuse or neglect; we may also disclose your protected health information if we believe you to be a victim of abuse, neglect, or domestic violence.

- **Health Oversight Activities:** We may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

You have the following rights with respect to the protected health information we maintain about you.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to us or to the business associate who maintains the medical information. If we would prefer to send you a summary or explanation of your medical information rather than the actual records, we may do so only with your consent and your agreement in advance to the fees imposed, if any. You may request your records be in paper or electronic format. We may charge a fee for the costs of copying, mailing or other supplies associated with mailing or copying your protected health information. We may deny your request in whole or in part to inspect and copy records in certain circumstances. If you are denied access to medical information, we will provide a written notice explaining the basis for the denial. You may also request that the denial be reviewed. Such request for review will either be approved or denied based on the grounds for denial. If the initial denial is reviewable, the person conducting the review will not be the same person who denied your original request. We will comply with the determination of the representative performing the review.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request and we retain the right to terminate an agreed to restriction. Such termination is only effective with respect to protected health information created or received after GTL has informed the individual of its termination of the restriction. Additionally requesting certain limitations may affect payment of benefits under your health plan. To request restrictions, you must make your request in writing to our Customer Service Department. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

You have the right to request and receive confidential communications. We will accommodate reasonable requests to send your protected health information to you at a different address, or other method of contact. We will not request an explanation from you as to the basis for the request. For example, you can ask that we only contact you at work or by mail. Requests for confidential communications must be made in writing, signed by you and sent to GTL. Your request must specify how or where you wish to be contacted.

You have the right to request an amendment of your protected health information. You may request an amendment of your health information contained in a designated record set for as long as the information is kept by GTL or any of our business associates. To request an amendment, you must send us your request in writing to the address included in the "Contact Information" section below, giving details of your request and why you are making it. If we deny your request for amendment in whole or in part, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement. We will provide you with a copy of any such rebuttal. In certain cases, we may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the designated record set kept by us; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.

You have the right to receive an accounting of certain disclosures. You have the right to request an accounting of most disclosures of protected health information made by us during the six years prior to the date the accounting is requested, subject to certain exceptions. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a cost-based reasonable fee.

You have the right to be notified following a breach of unsecured protected health information. You have the right to and will receive a notification of a breach of your unsecured protected health from GTL, or one of its business associates.

COMPLAINTS
If you believe your privacy rights have been violated, you may file a complaint in writing to us at the address shown below in the "Contact Information" section. You may also file a complaint in writing with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

THIS NOTICE IS SUBJECT TO CHANGE
We reserve the right to change the terms of this Notice and our privacy policies at any time. If we do, the new terms will be effective for all protected health information maintained by us, including protected health information received by GTL before the effective date of the new terms. If we do revise our privacy notice, a copy of the new notice will be posted on our web site at www.gtlic.com and/or sent to you if the changes are material.

EFFECTIVE DATE
This Notice is effective September 23, 2013.

CONTACT INFORMATION
If you have questions regarding this Notice or require further information, you may contact our Customer Service Department at 1-800-338-7452. Any written complaints should be directed to Guarantee Trust Life Insurance Company, Attention: Privacy Office, 1275 Milwaukee Avenue, Glenview, Illinois 60025.

GUARANTEE TRUST LIFE INSURANCE COMPANY

PLEASE GIVE TO PROPOSED INSURED

PRE-NOTICE TO PROPOSED INSURED
I understand that the insurance applied for shall not become effective until: a) approved and issued by GTL; and b) I have been furnished written notice of the effective date. If applicable, I have received the Guide to Health Insurance for people with Medicare and the Outline of coverage.

DO NOT CANCEL EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE OF APPROVAL FROM GTL
In completing this application for insurance, it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties such as family members; business associates; financial sources; friends; neighbors; or others with whom you are acquainted. This inquiry includes information as to your character; general reputation; personal characteristics; and mode of living, whichever may be applicable. You have the right to make written request within a reasonable time period for a disclosure of additional information concerning the nature and scope of the investigation. (See Disclosure Notice.)

NOTICE TO APPLICANT
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 covering 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 disclosed 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 use a “consumer reporting agency,” you have the right to: (1) ask to talk to 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 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.

NOTICE OF INFORMATION PRACTICES
GTL will need to obtain data about you and other persons proposed for insurance prior to issuing your coverage. Some data will be obtained from you and some from other sources. That data and any data that is collected at a later date, may in some cases be disclosed to third parties without your specific consent subject to the Company’s privacy policies. You have the right of access and correction to data received about you. But, data about a claim or a civil or criminal proceeding is excepted. Details on these procedures will be furnished on request.

Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, Illinois 60025

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

This is not Medicare Supplement Insurance

This insurance pays a fixed dollar amount, regardless of your expenses, for each day you meet the policy conditions. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- any expenses or services covered by the policy are also covered by Medicare

Medicare generally pays for most or all of these expenses.

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- hospitalization
- physician services
- outpatient prescription drugs if you are enrolled in Medicare Part D
- hospice
- other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.

√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare*, available from the insurance company.

√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).