GTL | GUARANTEE TRUST LIFE

Application to Guarantee Trust Life Insurance Company for Individual Graded Benefit Whole Life Insurance

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

PROPOSED INSURED **SEND DOCUMENTS TO: ☐ AGENT ☐ INSURED**

Last Name_____ First Name_____ M.I. _____

Home Address_____ City_____ State_____ Zip _____

Phone Work (____)_____ Home (____)_____

Social Security Number_____ ☐ Male ☐ Female Age_____ Date of Birth(mm/dd/yy)_____

E-mail Address_____ Weight_____ lbs. Height_____ ft._____ in.

Have you used any tobacco products in the last 12 months? ☐ Yes ☐ No

Plan Applied for: Graded Death Benefit **Face Amount: $_____**

Modal Premium
☐ Annual ☐ Semi Annual
☐ Quarterly ☐ Monthly

Amount of Premium Collected:
$_____

Requested Effective Date_____

Please Choose a Billing Option:
Select Billing Day
Billing Day: 1st - 28th _____
OR ☐ 2nd Wednesday ☐ 3rd Wednesday ☐ 4th Wednesday

Is Automatic Premium Loan Desired? ☐ Yes ☐ No

Owner (Completed only if other than the proposed insured.)

Full legal name of individual _____
(First, Middle, Last), Institution or Trust

Street Address_____ City_____ State_____ Zip _____

Home Phone Number (____)_____ Alternate Phone/Cell Number (____)_____

Relationship to proposed insured_____ Date of Birth (mm/dd/yy)_____

Social Security/Tax ID Number_____ ☐ Male ☐ Female

Beneficiary Information (Revocable)

Name of each primary beneficiary (Last, First, Middle Initial)	Relationship to Insured	% Share
		total must
		equal 100%
Name of each contingent beneficiary (Last, First, Middle Initial)	**Relationship to Insured**	**% Share**
		total must
		equal 100%

Do you have existing life insurance policies or annuity contracts? ☐ Yes ☐ No

Will the proposed insurance replace or change any existing life insurance policies or annuities? ☐ Yes ☐ No

If "Yes", to the above questions, please provide the company name and submit necessary replacement forms.

_____

If any answer to questions 1 through 5 is YES, you are not eligible for coverage.	
1. Within the last twenty four (24) months, have you been receiving kidney dialysis, require 24 hour continuous oxygen use (excluding CPAP), have an implanted defibrillator or received or been advised by a member of the medical profession to get an organ transplant?	☐ Yes ☐ No
2. Within the last twenty four (24) months have you been diagnosed with or treated by a member of the medical profession for Alzheimer's, dementia or memory loss?	☐ Yes ☐ No
3. Currently diagnosed as having, or receiving treatment by a member of the medical profession for invasive cancer (excluding Stage A Prostate Cancer, Carcinoma in Situ, and Squamous Cell/Basal Cell Carcinoma)?	☐ Yes ☐ No
4. Are you currently bedridden, confined to a hospital, nursing home, mental care facility, long term care facility, hospice or been diagnosed with a terminal illness?	☐ Yes ☐ No
5. Have you been diagnosed by a member of the medical profession as having the Human Immunodeficiency Virus (HIV), ARC or AIDS?	☐ Yes ☐ No

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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 criminal or motor vehicle records needed to underwrite my application for insurance. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes,) such information or records from any doctor, health professional, hospital, clinic, the Veterans Administration, insurance company, pharmacy benefit manager, pharmacies or pharmacy-related facility which have such information including any medical information provided to any affiliate insurance company on previous applications and medical information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from MIB, Inc. I authorize the Company, or its reinsurers, to make a brief report of my personal health information to MIB, Inc. 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. Although federal regulations require that the Company inform me of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. I agree this authorization will be valid for 24 months from the date signed. The time limit complies with the time limit, if any, permitted by applicable law in the state where the policy is delivered or issued for delivery. I or my authorized representative may have a photocopy of it. I have read or had read this authorization and I 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 by your state).

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.

This application may be completed by electronic or telephonic means. I acknowledge that the Company or its agent has verified my identity for this purpose in accordance with any applicable law or regulation and that if completed by electronic means, I have provided my consent and authorization to complete an electronic transaction to apply for coverage.

This authorization shall constitute an electronic signature, which is legally binding, and has the same effect as if I had physically signed this application. If this application is completed by phone, I authorize the Company or its agent to accept my voice signature response.

Authorization for Electronic Delivery of Documents

I acknowledge receipt of the Consent for Use of Electronic Records and Electronic Signatures Disclosure, which describes the requirements for Electronic Policy Fulfillment and Communications, as well as my right to withdraw my consent for Electronic Records. Guarantee Trust Life Insurance Company will be held harmless for any claim, liability, loss or cost, when we have used reasonable procedures to confirm communications and transactions are authorized and genuine and those procedures have been followed.

☐ By checking this box, I authorize Guarantee Trust Life Insurance Company to provide the Electronic Delivery of Documents.