**GUARANTEE TRUST LIFE INSURANCE COMPANY**
**1275 MILWAUKEE AVENUE • GLENVIEW • ILLINOIS 60025 • 1-800-338-7452**

## APPLICATION FOR MEDICARE SUPPLEMENT INSURANCE

**APPLICANT** Last Name _____ First Name _____ M.I. _____

Soc. Security # _____ Age _____ Date of Birth _____/_____/_____ Sex _____

Phone Number (____) _____ E-mail Address _____

**ADDRESS** Number & Street _____ City _____ State _____ Zip _____

## Plan Selection & Payment Information

1. I apply for Medicare Supplement Plan:
   ☐A ☐F ☐G ☐N
2. Applicant Height ___ (Ft.) ___ (In.) Weight ___ (Lbs.)
3. Have you used any tobacco product in the last 12 months? ☐ Yes ☐ No
4. Rate Class:* ☐ Preferred ☐ Standard
   **Agent: Please refer to the Underwriting Guide for eligibility/Rate Class selection.*
5. Does any person currently residing in your household have GTL Medicare Supplement coverage or currently making application for such coverage
   ☐ Yes ☐ No
   *If "Yes", applicant and household member may be eligible for a multi policy household discount.*
6. Requested Effective Date or Replacement Date: _____

7. Premium Mode:
   ☐ Annual ☐ Semi Annual
   ☐ Quarterly ☐ Monthly Bank Draft

Requested Draft Date:

_____

Application Fee: $ _____ 25.00 _____

Total Modal Premium: $ _____

Premium Paid with Application: $ _____

## PAYOR INFORMATION (To be completed only if payor is other than the insured)

Name _____ Relationship _____

Street Address _____ City _____ State _____ Zip _____

## MEDICARE COVERAGE QUESTIONS Questions 8 through 13 must be answered.

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed issue of a Medicare Supplement insurance policy, or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one of our Medicare Supplement plans. Please include a copy of the notice from your prior insurer with your application. **PLEASE ANSWER ALL OF THE QUESTIONS COMPLETELY**.
Please mark Yes or No with an "X". To the best of your knowledge:

| | |
|---|---|
| 8. Are you covered under Medicare Parts A & B?..... **(If the answer is "No", do not submit the application)** If yes, what is your Medicare claim number? (exactly as it appears on your Medicare Card) _____ | ☐ Yes ☐ No |
| 9. Are you covered for medical assistance through the state Medicaid program? **NOTE TO APPLICANT:** If you are participating in a "Spend-Down Program" and have not met your "Share of Cost," please answer NO to this question. If you answer yes, | ☐ Yes ☐ No |
| **a.** Will Medicaid pay your premiums for this Medicare Supplement policy? ……..... | ☐ Yes ☐ No |
| **b.** Do you receive any benefits from Medicaid OTHER THAN payments toward your Medicare Part B premium?..... **(If the answer to 9a. or 9b. is "Yes," do not submit the application.)** | ☐ Yes ☐ No |
| 10. **a.** Did you turn age 65 in the last 6 months? ……..... | ☐ Yes ☐ No |
| **b.** Did you enroll in Medicare Part B in the last 6 months or will you enroll in Medicare Part B in the next 6 months?..... If yes, what is/was the effective date? _____ | ☐ Yes ☐ No |
| 11 **a.** Do you have another Medicare Supplement policy in force?..... | ☐ Yes ☐ No |
| **b.** If so, with what company and what plan do you have? ..... | |
| **c.** If so, do you intend to replace your current Medicare Supplement policy with this policy? | ☐ Yes ☐ No |

12. **a.** If you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan, or a Medicare HMO or PPO) fill in your start and end dates below. If you are still covered under this plan, leave "END" blank.
START _____/_____/_____ END _____/_____/_____

**b.** If you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy? …… ☐ Yes ☐ No

**c.** Was this your first time in this type of a Medicare plan?……..... ☐ Yes ☐ No

**d.** Did you drop a Medicare Supplement policy to enroll in the Medicare plan? ……..... ☐ Yes ☐ No

13. Have you had coverage under any other health insurance within the past 63 days?……..... ☐ Yes ☐ No
(For example, Railroad Retirees, teachers plans, an employer union, group major medical or individual plan)

**a.** If so, with what company and what kind of policy?

_____

_____

**b.** What are your dates of coverage under the other policy?

START _____/_____/_____ END _____/_____/_____
*(If you are still covered under the other policy, leave the "END" blank.)*

**HEALTH QUESTIONS Questions 14 through 22 must be answered.**

**If you have enrolled in Medicare Part B within the past 6 months, you do not have to answer the following questions. Otherwise you must answer the following questions. Please note, if you answer "Yes" to any question 14 through 21, you are not eligible for coverage.**

14. In the past 10 years, have you been advised by a physician to have surgery, medical tests, treatment or therapy that has not been performed? ..... ☐ Yes ☐ No

15. Have you been advised by a physician that surgery may be required within the next 12 months for cataract(s)? ..... ☐ Yes ☐ No

16. Have you been hospitalized two or more times within the last two years? ..... ☐ Yes ☐ No

17. Are you currently hospitalized, bedridden, living in a nursing facility, using a wheelchair or a motorized mobility aid?..... ☐ Yes ☐ No

18. In the past 10 years, have you had an organ transplant or are you taking medication due to an organ transplant? ..... ☐ Yes ☐ No

19. In the past 10 years, have you been diagnosed with emphysema, chronic pulmonary disorder other than asthma, Parkinson's disease, systemic lupus, myasthenia gravis, multiple sclerosis, ALS (amyotrophic lateral sclerosis), osteoporosis with a fracture or fractures, cirrhosis, Alzheimer's disease, senile dementia or any other cognitive disorder, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC,) or Human Immunodeficiency Virus (HIV) infection? ..... ☐ Yes ☐ No

20. If you have been diagnosed with diabetes, in the past 10 years, have you also been diagnosed with retinopathy, diagnosed with neuropathy, diagnosed with heart disease, treated for high blood pressure with three or more medications, or advised by a medical professional to take more than 50 units of insulin daily or more than two medications (insulin or oral)? ..... ☐ Yes ☐ No

21. Within the past two years, have you been treated or been advised by a physician to have treatment for internal cancer, melanoma, alcoholism, drug abuse, mental or nervous disorder requiring psychiatric hospitalization, chronic hepatitis, chronic kidney disease, coronary artery disease, carotid artery disease, heart rhythm disorders including use of pacemaker or defibrillator, heart attack, congestive heart failure, enlarged heart, stroke, Transient Ischemic Attack (TIA,) heart valve surgery, peripheral vascular disease, rheumatoid arthritis, crippling or disabling arthritis, or amputation caused by disease? ☐ Yes ☐ No

22. Are you taking or have you taken any prescription or over-the-counter medications within the past 12 months? If yes, list the medication(s) name, frequency and dosage, and diagnosis/condition/ reason for the medication..... ☐ Yes ☐ No

**Please attach a separate sheet if needed**

| | |
|---|---|
| Medication name (copy from pharmacy label) | |
| Frequency and dosage | |
| Diagnosis / Condition / Reason for medication | |
| Medication name (copy from pharmacy label) | |
| Frequency and dosage | |
| Diagnosis / Condition / Reason for medication | |
| Medication name (copy from pharmacy label) | |
| Frequency and dosage | |
| Diagnosis / Condition / Reason for medication | |

## DISCLOSURE & AUTHORIZATION

**DISCLOSURE:** You do not need more than one Medicare Supplement policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages. You may be eligible for benefits under Medicaid and may not need a Medicare Supplement policy. If, after purchasing this policy, you become eligible for Medicaid, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medicaid for 24 months. You must request this suspension within 90 days of becoming eligible for Medicaid. If you are no longer entitled to Medicaid, your suspended Medicare Supplement policy, (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medicaid eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension.

If you are eligible for, and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances, and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage, but will otherwise be substantially equivalent to your coverage before the date of the suspension. Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medicaid program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-Income Medicare Beneficiary (SLMB).

**APPLICANT'S AUTHORIZATION & AGREEMENT:** 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, pharmacy benefit manager, pharmacy or pharmacy-related facility, 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 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 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. 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 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 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 agent or to the attention of the Underwriting Manager.

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

**ACKNOWLEDGEMENTS:** The Applicant represents and agrees as follows: 1) That the statements contained in the application concerning past and present health are complete. 2) Any coverage issued as a result of this application shall, together with this application, constitute a single and entire contract of insurance. 3) No agent or any other person is authorized to accept risks, pass on insurability, make or modify contracts or waive any of the Company's rights or requirements. 4) Any insurance issued as a result of the application will not take effect unless and until the full first premium is paid and the policy is delivered during such person's lifetime. 5) Provisions concerning exceptions, exclusions, limitations and renewal of the insurance plan which has been applied for, have been explained and are understood. 6) The applicant shall be owner of any insurance applied for. 7) The applicant acknowledges receipt of the Outline of Coverage, and has read the authorization and received copies of the "Notice to Applicant, Parts 1 and 2" describing MIB, Inc. and explaining the rights of the applicant under the Fair Credit Reporting Act.

**AGREEMENT:** I have read, or had read to me, the completed application. I hereby agree that: 1) all the statements and answers in this application are complete and true to the best of my knowledge and belief; and 2) **no insurance will be effective until my policy is issued.**

I agree that I may receive my policy and other GTL correspondence electronically. I acknowledge receipt of the Electronic Delivery and Communications Disclosure, which describes the requirements for Electronic Policy Fulfillment and Communications, as well as my right to opt-out of Electronic Policy Fulfillment and receive a paper copy of my policy free of charge.

**Caution: If your answers on this application are incorrect or untrue, Guarantee Trust Life Insurance Company may deny benefits or rescind your policy.**

**We are required to give you this notice: Any person who, with the intent to defraud or knowledge that he is facilitating a fraud against the insurer, submits an application or files a claim containing false, incomplete, or deceptive statements of material fact may be guilty of insurance fraud.**

**Applican't Signature** **City & State Signed** **Date**

**AGENT'S REPORT:** List of health policies or certificates I have sold to the Applicant in the last 5 years which are either in force or no longer in force:

| NAME OF INSURER | POLICY TYPE |
|---|---|
| | |
| | |
| | |
| | |

**AGENT'S STATEMENT**

I certify: 1) I have accurately recorded the information supplied by the Applicant; 2) I have given the Applicant an Outline of Coverage for the policy being applied for and the *Guide to Health Insurance for People on Medicare*; and 3) I have reviewed the current health coverage of the Applicant and have completed the chart above, as applicable. I find that additional coverage of the type and amount applied for is appropriate for the Applicant's needs.

**Agent's Signature** **Agent's Name (please print)** **Agent Code**

**Agent's E-mail Address** *(Agent signature not required if sold through the mail.)*

**TYPE OF SALE:** ☐ In Person ☐ Telephone ☐ On-line ☐ Mail

APPH4-15-ID

## MONTHLY PRE-AUTHORIZED PREMIUM PAYMENT PLAN

*Authorization to Honor Withdrawals to be drawn by Guarantee Trust Life Insurance Company.*

TO _____
Name of my Bank

As a convenience to me, I request and authorize you to charge the account shown below for premiums drawn by and payable to the order of Guarantee Trust Life Insurance Company, Glenview, Illinois, provided there are sufficient funds in my account to pay the same upon presentation.

Account # Bank Routing #

Account Type ☐ Checking Account (Attach a Voided "Sample" check)

☐ Savings Account (Attach a Voided "Sample" check if applicable, or a Deposit slip)

I agree that my rights in respect to each payment shall be the same as if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I further agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

Printed name of insured if different from premium payer

Premium payer's signature, as it appears on bank records

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

**NOTICE TO APPLICANT – PARTS 1 AND 2**

**Part 1: Fair Credit Reporting Act and Privacy Act Pre-Notification**

The application you completed for insurance with us, in most cases, gives us all the information we need. In certain cases, we may need more information.

If we need more information, we may get it by talking to other persons you know including, but not limited to, your agent or other insurance companies you have applied to. We may ask an independent "consumer reporting agency" to help us verify facts or get additional facts.

We may collect information concerning your health, job and financial situation, as well as your character, general reputation and mode of living. We will not collect information relating to your sexual orientation.

The personal information we obtain about you is treated as confidential and will not be discussed to other persons or organizations without your written authorization except to the extent necessary as permitted by law, for the conduct of our business. But any information collected by a "consumer reporting agency" may be shared by the agency with others who use such information, but only to the extent which the Fair Credit Reporting Act Permits. You have a right of access, and right of correction, concerning recorded personal information obtained in our file. In order to exercise these rights, you must contact us in writing requesting access or correction.

You have no access right to privileged information. If we used a "consumer reporting agency," you have the right to: (1) ask to talk with them and (2) ask them about their report. You may write us for the name and address of the agency. This paragraph is not intended as a complete description of your right of access and correction. If you would like a more complete description of our insurance information and Privacy Protection Practices, please write: Guarantee Trust Life Insurance Company, 1275 Milwaukee Avenue Glenview, IL 60025.

**Part 2: Notification Regarding MIB, Inc.**

Information regarding your insurability will be treated as confidential. Guarantee Trust Life Insurance Company or its reinsurers may, however, make a brief report thereon to MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc., will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB, Inc.'s file, you may contact MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address to the MIB, Inc. information office is 50 Braintree Hill Park, Suite 400, Braintree Massachusetts 02184-8734, telephone number (866) 692-6901, e-mail address infoline@mib.com. Guarantee Trust Life Insurance Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

— — — — — — — — — — — — — — — — — — — — — — — — — — —

**RECEIPT** **DATE** _____

Received of _____ the sum of $ _____ and application for insurance to Guarantee Trust Life Insurance Company. If for any reason the application is declined this payment will be refunded. No liability is created or assumed by the Company, except for refund of this payment, until the insurance applied for has been issued.

_____

Agent's Signature

If you do not receive your policy 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**
**Electronic Delivery and Communications Disclosure**

Unless otherwise requested by you, all documents that form our insurance relationship will be provided to you in electronic format. These documents include:

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

In order to access the documents electronically, you will need to:

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

You are responsible for accessing, opening and reading communication we send in electronic format. We will consider Electronic Communications to be received by you upon successful delivery to the designated e-mail address you provide. To ensure our Electronic Communications are not blocked in e-mail or spam filters, please add our domain, "gtlic.com", to your safe sender list.

**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. 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.