

Guarantee Trust Life Insurance Company

Group Major Medical Insurance Application

Applicant's Instructions: (If not applying on-line, please print in blue or black ink. Corrections should be lined through and initialed by the applicant. Do not use white out.) For additional dependents, provide required information on the Supplement to the Application, sign and date it. Applicant 1 is primary applicant. List only persons who are applying for coverage, except on child(ren) only coverage -- parent, though not applying, must be listed as primary applicant.

Home Office Endorsement
Case No.: _____
Eff. Date: _____
Other: _____
Approved By: _____

<input type="checkbox"/> New Application	<input type="checkbox"/> Add On	<input type="checkbox"/> Rewrite
<input type="checkbox"/> Monthly Bank Draft	<input type="checkbox"/> Monthly Direct	
<input type="checkbox"/> Quarterly Direct	<input type="checkbox"/> Semi-Annual Direct	
<input type="checkbox"/> List Bill	<input type="checkbox"/> New	<input type="checkbox"/> Add On
List Bill Case No. _____		
<input type="checkbox"/> Third Party Payor Plan	<input type="checkbox"/> New	<input type="checkbox"/> Add On
Mail cert./pol. to: <input type="checkbox"/> Agent <input type="checkbox"/> Insured		
(If not checked, will be sent to insured.)		

A. General Information

1. a. Applicant's Name (First, M.I., Last)	5. a. Applicant's Employer	Address
b. Resident Street Address (PO Box not acceptable)	b. Occupation/Title/Duties	
c. City, State, Zip	c. Check if applicable:	
d. Applicant's E-mail Address	<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Partner
2. a. Applicant's Billing Address	<input type="checkbox"/> Owner	
<input type="checkbox"/> Same as Resident Address	6. Spouse's Name (if applying) (First, Middle, Last)	
b. City, State, Zip	7. a. Spouse's Work Phone	
3. a. Applicant's Home Phone	b. Best Time To Call:	
b. Applicant's Work Phone	<input type="checkbox"/> Home	<input type="checkbox"/> Work
c. Best Time To Call:	_____ a.m.	_____ 5:30 p.m.
<input type="checkbox"/> Home	<input type="checkbox"/> p.m.	
4. Applicant's Marital Status:	8. a. Spouse's Employer	Address
<input type="checkbox"/> Married	b. Occupation/Title/Duties	
<input type="checkbox"/> Single	c. Check if applicable:	
<input type="checkbox"/> Divorced	<input type="checkbox"/> Sole Proprietor	<input type="checkbox"/> Partner
<input type="checkbox"/> Widowed	<input type="checkbox"/> Owner	
<input type="checkbox"/> Legally Separated		

9. List All Applicants Applying for Coverage (First, MI, Last Name)	Relationship to Applicant	Ht. ft., in.	Wt. lbs.	Birthdate mo./day/yr.	Sex M/F	Child Age 19 & Over Must Be Full-Time Student --List College Attending	Social Security Number or Valid Work Visa Number, if applicable
	Applicant						
	Spouse						
	Dependent Child						
	Dependent Child						
	Dependent Child						
	Dependent Child						

10. Are all applicants applying for insurance living at the same residence? Yes No If no, please provide explanation indicating person(s) and reason _____
11. Is any eligible family member not applying for insurance under this application? Yes No
If yes, who and why? _____
Who is to be insured (check all that apply)? Applicant Spouse Children Children Only
12. Has any adult applicant applying for coverage smoked or used any tobacco products such as cigarettes, cigars, pipes, chewing tobacco or snuff at any time during the last 12 months? Applicant: Yes No Spouse: Yes No
13. **Requested Effective Date** (check one) (subject to approval):
- I do not have existing health insurance coverage and request the Company to assign the first available effective date following underwriting approval (1st or 15th of the month). I understand I cannot change this date.
- I am replacing existing health insurance coverage and request the Company to assign the effective date as follows: The first available effective date following approval (1st or 15th of the month) OR Month _____ 1st or 15th
I understand this date can only be changed prior to issue and if I have provided proof of coverage from my prior carrier.
- Other Day _____ ("Other" only available to persons applying under HIPAA.)
- If the Company is unable to approve the application within 60 days of the application date, a new, currently dated application may be required.

DO NOT CANCEL ANY EXISTING HEALTH INSURANCE UNTIL RECEIVING WRITTEN NOTICE OF APPROVAL.

Total Amount Submitted \$ _____ Make check payable to Guarantee Trust Life Insurance Company. DO NOT MAKE CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK.

B. Type of Coverage Requested

1. Assur-Care	Coinsurance/Stop Loss
<input type="checkbox"/> Advantage PPO	<input type="checkbox"/> PPO 80/20% to \$10,000; NonPPO 60/40% to \$20,000 <input type="checkbox"/> PPO 50/50% to \$10,000; NonPPO 50/50% to \$20,000 <input type="checkbox"/> PPO 50/50% to \$5,000; NonPPO 50/50% to \$10,000 <input type="checkbox"/> PPO 50/50% to \$20,000; NonPPO 50/50% to \$40,000 Rx Drug Card Benefit MUST SELECT ONE (3 Tier Rx Card = Generic/Formulary/Brand): <input type="checkbox"/> 3 Tier Rx Copay w/\$0 Rx Ded. for Generic and <input type="checkbox"/> \$250 <input type="checkbox"/> \$500 Rx Ded. for Formulary/Brand <input type="checkbox"/> Generic Copay Only w/\$0 Rx Ded.
<input type="checkbox"/> Complete PPO	<input type="checkbox"/> PPO 80/20% to \$10,000; NonPPO 60/40% to \$20,000 <input type="checkbox"/> PPO 50/50% to \$10,000; NonPPO 50/50% to \$20,000 <input type="checkbox"/> PPO 50/50% to \$5,000; NonPPO 50/50% to \$10,000 <input type="checkbox"/> PPO 50/50% to \$20,000; NonPPO 50/50% to \$40,000 Rx Drug Card Benefit MUST SELECT ONE (3 Tier Rx Card = Generic/Formulary/Brand): <input type="checkbox"/> 3 Tier Rx Copay w/\$0 Rx Ded. for Generic and \$500 Rx Ded. for Formulary/Brand <input type="checkbox"/> Generic Copay Only w/\$0 Rx Ded.
Deductible: <input type="checkbox"/> Advantage: <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> Complete: <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500	
<input type="checkbox"/> Optional Supplemental Accident <input type="checkbox"/> Optional Physician Office Visit Copay (Complete Plan only) <input type="checkbox"/> Optional Routine Preventive Care Benefits	
<input type="checkbox"/> Optional 24 Hour Occupational Coverage*: <input type="checkbox"/> Applicant <input type="checkbox"/> Spouse (*If elected, the applicable individual(s) must be gainfully employed and a sole proprietor, partner, owner or other individual who are eligible to opt out of Workers' Compensation and done so per questions D1 and D2 below.)	

2. **ALL PLANS:** Indicate desired PPO Network _____

C. Preferred Health Discount Questions for Applicant/Spouse - Age 18-39

I am applying for the Preferred Health Discount Applicant: Yes No Spouse: Yes No
 If neither the applicant or the spouse are applying for the Preferred Health Discount, skip to Section D.

In order to pre-qualify for the Preferred Health Discount, the adult applicant and adult applicant's spouse, if applying, must be: • age 18 but not older than age 39; and • able to answer "No" to questions 2 through 6 below. The following questions are being presented to "pre-qualify" the adult applicant and adult spouse, if applying, for the Preferred Health Discount. Completion of this section does not guarantee you will qualify for such discount.

	Applicant		Spouse	
	Yes	No	Yes	No
Please check the applicable answer to the following questions:				
1. Is the applicant or spouse replacing current major medical health insurance?.....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If the answer is no, have you:				
a) Had a comprehensive physical exam within the last 12 months (inclusive of build, blood, urine and tobacco testing)?; or	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) Do you agree to complete a paramedical exam at no cost to you?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Does your height and weight fall outside of the normal height and weight requirements? (Refer to the current Quick Reference Guide.).....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Has the applicant or spouse been diagnosed with, treated for, or advised to seek treatment for:				
a) high or low blood pressure within the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) a blood pressure reading in excess of 140/90 in the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) total cholesterol in excess of 190 mg within the last 2 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d) any mental or nervous disorder or alcohol or drug abuse within the past 10 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Has the applicant or spouse (whether applying or not) received any infertility treatments or medication within the past 3 years?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Has the applicant or spouse within the past 3 years:				
a) used any form of tobacco?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b) had any DUI, DWI or reckless driving convictions?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c) been advised to schedule any tests, seek treatment, or have surgery that is pending or not been pursued?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Has the applicant or spouse within the past 2 years been prescribed any maintenance dose medication for ongoing treatment of a chronic or persistent medical condition?	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. General Questions (Must be completed by all applicants.)

- 1. Is the applicant, if applying, covered by Workers' Compensation or similar legislation? N/A Yes No
If no, is the applicant eligible to opt out of Workers' Compensation in their state?..... Yes No
- 2. Is the spouse, if applying, covered by Workers' Compensation or similar legislation?..... N/A Yes No
If no, is the spouse eligible to opt out of Workers' Compensation in their state?..... Yes No
- 3. Has any applicant had prior medical insurance or is currently insured with Guarantee Trust Life Insurance Company? Yes No
If yes, who?_____ Certificate ID #_____ Date such coverage ended_____
- 4. Has any applicant had any form of health insurance (check applicable box): denied ridered rated-up rescinded Yes No
If yes, who?_____ What was the reason?_____
- 5. a. Is each applicant applying for insurance a U.S. citizen?..... Yes No
b. If no, do they have resident visas or valid work permits and have resided in the U.S. for the prior six (6) months?..... Yes No
(If yes, must attach copy of valid visa or work permit. If no, applicant is not eligible for this coverage.)
- 6. Is any applicant currently covered under Medicare, Medicaid or other government-sponsored health insurance plan? Yes No
If yes, coverage cannot be issued to such individual.

E. Medical History

Please answer the following questions for all persons applying for coverage. Failure to provide full details may result in rescission or reformation of insurance coverage. Complete details for all "yes" answers must be provided in Section F.

- 1. Are you or any family member, whether or not applying for coverage, currently pregnant or an expectant parent or in the process of adopting a child? If yes, then no family member is eligible to apply for coverage even if the pregnant individual is not applying for insurance. Yes No
- 2. Does any applicant fly or plan to fly as a pilot, do any land/water racing, parachuting, skydiving, hang gliding, bungee jumping or rodeo activities? .. Yes No
- 3. Are any applicants currently totally or partially disabled or receiving any payments due to a disability? If yes, who?_____. Yes No
What condition(s) caused the disability?_____
- 4. Has any applicant ever had a sex transformation or commenced medical/drug treatment for a sex transformation?..... Yes No
- 5. Has any applicant ever had fixation/prosthetic devices present including, but not limited to: plates, screws, pins, implants (including breast implants), pacemakers, valve replacements or transplants? Yes No
- 6. Has any applicant ever been arrested for, or had his/her driver's license suspended or revoked for, driving while under the influence of alcohol and/or illegal drugs? If yes, identify person(s), supply driver's license number(s) and state of issue Yes No

- 7. Has any applicant, in the past 10 years been diagnosed or treated by a member of the medical profession for alcoholism or alcohol abuse, been advised by a physician that they have used alcohol in excess, or been advised to modify drinking habits for any reason? Yes No
- 8. Has any applicant, in the past 10 years, been diagnosed with or been treated by a member of the medical profession for drug (either legal or illegal) misuse, abuse or addiction, chemical substance use or addiction, or for tobacco abuse? Yes No
- 9. Has any applicant, in the past 10 years, used any illegal drugs? Yes No
- 10. Has any applicant, in the past 5 years, been informed by a member of the medical profession of an abnormal test result?..... Yes No
- 11. Have you or any member of your family proposed for coverage under this plan ever tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS caused by the HIV infection or other sickness or condition derived from such infection?..... Yes No
- 12. Has any applicant, in the past 3 years, been advised by a member of the medical profession to have any test, examination or surgery that has not been completed or been informed of the potential of surgery in the future? Yes No
- 13. Has any applicant, in the last 12 months, had a weight loss of more than 15 pounds? If yes, what was prior weight? _____ ... Yes No
Reason for weight loss _____
- 14. Has any applicant, in the past 10 years, had any symptoms, testing, treatment, diagnosis, consultation, counseling or been prescribed medication by a member of the medical profession for any of the following physical systems, structures or organs, illnesses, injuries, diseases or disorders, whether physical or psychological (Where multiple conditions exist under one question, **check all that apply and provide complete details in Section F for each condition.**):

- 14A. Respiratory System:
- | | | | |
|--|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Asthma | <input type="checkbox"/> Emphysema or COPD | <input type="checkbox"/> Shortness of Breath, Breathing Difficulty |
| <input type="checkbox"/> Other Lung Disorder | <input type="checkbox"/> Pulmonary Hypertension | <input type="checkbox"/> Chronic Cough | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Cystic Fibrosis | <input type="checkbox"/> Spitting Up Blood | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Tuberculosis | | | |

No applicant, in the past 10 years, has had any symptoms, testing, treatment, diagnosis, consultation, counseling or been prescribed medication for any of the listed Respiratory System conditions.

14B. *Circulatory System:*

<input type="checkbox"/> Heart Disease	<input type="checkbox"/> Heart Attack	<input type="checkbox"/> Coronary Artery Disease	<input type="checkbox"/> Low/High Blood Pressure
<input type="checkbox"/> Elevated Cholesterol	<input type="checkbox"/> Elevated Triglycerides	<input type="checkbox"/> Stroke or TIA	<input type="checkbox"/> Varicose Veins
<input type="checkbox"/> Blood Disorder	<input type="checkbox"/> Angina Pectoris (Chest Pain)	<input type="checkbox"/> Mitral Valve Prolapse	<input type="checkbox"/> Palpitations/Irregular Heartbeat
<input type="checkbox"/> Valvular Disease or Disorder	<input type="checkbox"/> Aneurysm	<input type="checkbox"/> Embolism	<input type="checkbox"/> Phlebitis
<input type="checkbox"/> Anemia	<input type="checkbox"/> Blood Clot	<input type="checkbox"/> Peripheral Vascular Disease/Vascular Disease or Disorder	

No applicant, in the past 10 years, has had any symptoms, testing, treatment, diagnosis, consultation, counseling or been prescribed medication for any of the listed Circulatory System conditions.

14C. *Digestive System:*

<input type="checkbox"/> Ulcer	<input type="checkbox"/> Colon Polyps	<input type="checkbox"/> Gastritis	<input type="checkbox"/> Spleen
<input type="checkbox"/> Gallbladder/Gall Stones	<input type="checkbox"/> Stomach	<input type="checkbox"/> Hernia of Any Kind	<input type="checkbox"/> Jaundice
<input type="checkbox"/> Rectum	<input type="checkbox"/> Hemorrhoids	<input type="checkbox"/> Esophagus	<input type="checkbox"/> Reflux (GERD)
<input type="checkbox"/> Liver, Bile Duct, Biliary	<input type="checkbox"/> Enteritis, Gastroenteritis	<input type="checkbox"/> Diverticulitis, Diverticulosis	<input type="checkbox"/> Colitis, Spastic Colon, Irritable Bowel
<input type="checkbox"/> Ulcerative Colitis or Crohn's	<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Anal Fissure	<input type="checkbox"/> Elevated Liver Function Tests
<input type="checkbox"/> Hepatitis: <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> C	<input type="checkbox"/> Obesity/Morbid Obesity (including, but not limited to, gastric by-pass, stapling, lap band procedure)		

No applicant, in the past 10 years, has had any symptoms, testing, treatment, diagnosis, consultation, counseling or been prescribed medication for any of the listed Digestive System conditions.

14D. *Endocrine System:*

<input type="checkbox"/> Pancreas	<input type="checkbox"/> Diabetes	<input type="checkbox"/> Impaired Glucose Tolerance	<input type="checkbox"/> High or Low Blood Sugar
<input type="checkbox"/> Pituitary Disorder	<input type="checkbox"/> Thyroid	<input type="checkbox"/> Goiter	<input type="checkbox"/> Addison's Disease
<input type="checkbox"/> Adrenal or Other Glandular Disorder			

No applicant, in the past 10 years, has had any symptoms, testing, treatment, diagnosis, consultation, counseling or been prescribed medication for any of the listed Endocrine System conditions.

14E. *Urinary System:*

<input type="checkbox"/> Kidney Stones	<input type="checkbox"/> Kidney Disorder	<input type="checkbox"/> Urinary Tract Infection	<input type="checkbox"/> Bladder, Bladder Stones
<input type="checkbox"/> Urinary Incontinence			

No applicant, in the past 10 years, has had any symptoms, testing, treatment, diagnosis, consultation, counseling or been prescribed medication for any of the listed Urinary System conditions.

14F. *Male or Female Reproductive System or Genitalia:*

<input type="checkbox"/> Caesarean Section	<input type="checkbox"/> Complicated Pregnancy	<input type="checkbox"/> Miscarriage	<input type="checkbox"/> Ovaries, Ovarian Cyst
<input type="checkbox"/> Infertility	<input type="checkbox"/> Impotency	<input type="checkbox"/> Sexually Transmitted Disease	<input type="checkbox"/> Genital Warts
<input type="checkbox"/> Menstrual Disorders	<input type="checkbox"/> Uterine Fibroids	<input type="checkbox"/> Uterus	<input type="checkbox"/> Cervix, Abnormal Pap Smear
<input type="checkbox"/> Endometriosis	<input type="checkbox"/> Premenstrual Syndrome	<input type="checkbox"/> Herpes	<input type="checkbox"/> Prostate, Elevated PSA

No applicant, in the past 10 years, has had any symptoms, testing, treatment, diagnosis, consultation, counseling or been prescribed medication for any of the listed Reproductive System or Genitalia conditions.

14G. *Musculo-Skeletal System:*

<input type="checkbox"/> TMJ/Jaw Disorder	<input type="checkbox"/> Back, Spine, Vertebrae	<input type="checkbox"/> Fibromyalgia	<input type="checkbox"/> Connective Tissue Disease or Disorder
<input type="checkbox"/> Rheumatism	<input type="checkbox"/> Bursitis or Tendonitis	<input type="checkbox"/> Lupus Erythematosus	
<input type="checkbox"/> Muscular Dystrophy	<input type="checkbox"/> Collagen Vascular Disorder	<input type="checkbox"/> Muscles, Ligaments, Tendons, Cartilage	
<input type="checkbox"/> Intervertebral Discs, Bulging, Herniated or Slipped		<input type="checkbox"/> Arthritis, Osteo, Rheumatoid, Psoriatic	
<input type="checkbox"/> Bone Density, Deformity, Infection, Fractures or Dislocation		<input type="checkbox"/> Spinal Manipulation or Chiropractic Adjustments	
<input type="checkbox"/> Scleroderma	<input type="checkbox"/> Joint Disorders or Replacements: <input type="checkbox"/> Elbow <input type="checkbox"/> Knee <input type="checkbox"/> Hip <input type="checkbox"/> Shoulder <input type="checkbox"/> Ankle <input type="checkbox"/> Hand <input type="checkbox"/> Foot		

No applicant, in the past 10 years, has had any symptoms, testing, treatment, diagnosis, consultation, counseling or been prescribed medication for any of the listed Musculo-Skeletal System conditions.

14H. *Nervous System:*

<input type="checkbox"/> Epilepsy	<input type="checkbox"/> Convulsions	<input type="checkbox"/> Seizures	<input type="checkbox"/> Paralysis
<input type="checkbox"/> Cerebral Palsy	<input type="checkbox"/> Head Injury	<input type="checkbox"/> Alzheimer's	<input type="checkbox"/> Parkinson's Disease
<input type="checkbox"/> Dementia Disease or Disorder	<input type="checkbox"/> Multiple Sclerosis	<input type="checkbox"/> Brain Disorder	<input type="checkbox"/> Severe/Chronic Headaches or Migraines
<input type="checkbox"/> ALS (Lou Gehrig's Disease)	<input type="checkbox"/> Spinal Cord Injury or Disorder	<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Down's Syndrome
<input type="checkbox"/> Central Nervous System or Neurological Disorder		<input type="checkbox"/> Dizziness, Fainting Spells, Loss of Consciousness	

No applicant, in the past 10 years, has had any symptoms, testing, treatment, diagnosis, consultation, counseling or been prescribed medication for any of the listed Nervous System conditions.

14I. *Mental or Nervous Disorder:*

<input type="checkbox"/> Anxiety	<input type="checkbox"/> Depression	<input type="checkbox"/> Eating Disorder	<input type="checkbox"/> Attention Deficit/ADHD
<input type="checkbox"/> Learning/Behavioral Disorder	<input type="checkbox"/> Neuroses or Psychoses	<input type="checkbox"/> Mental Retardation	<input type="checkbox"/> Bipolar Disorder
<input type="checkbox"/> Sleep Disorder	<input type="checkbox"/> Chemical Imbalance	<input type="checkbox"/> Suicide Attempt; Suicide Contemplation	
<input type="checkbox"/> Central Nervous System or Neurological Disorder		<input type="checkbox"/> Psychiatric or Psychological Treatment or Counseling	

No applicant, in the past 10 years, has had any symptoms, testing, treatment, diagnosis, consultation, counseling or been prescribed medication for any of the listed Mental or Nervous Disorder conditions.

14J. *Miscellaneous:*

<input type="checkbox"/> Speech	<input type="checkbox"/> Breast Disease or Disorder	<input type="checkbox"/> Skin Disorders, Burns, Acne	<input type="checkbox"/> Basal Cell or Squamous Cancer
<input type="checkbox"/> Sleep Disorder, Insomnia		<input type="checkbox"/> Cancer, Tumors, Cysts, Polyps, Growths (provide location, type, treatment)	
<input type="checkbox"/> Eyes, Glaucoma, Cataracts, Blurred Vision, Detached Retina		<input type="checkbox"/> Immune System Disorder, Chronic Fatigue Syndrome	
<input type="checkbox"/> Sleep Apnea or Use of a Sleeping Monitoring Device		<input type="checkbox"/> Lymphadenopathy (enlarged lymph nodes), Lymphadenitis	
<input type="checkbox"/> Nose, Deviated Septum, Throat or Tongue, Tonsils, Adenoids		<input type="checkbox"/> Ears, Otitis Media, Tubes in Ears	
<input type="checkbox"/> Lesions of the Skin or Mouth		<input type="checkbox"/> Premature Birth/Birth Development Disorders	

No applicant, in the past 10 years, has had any symptoms, testing, treatment, diagnosis, consultation, counseling or been prescribed medication for any of the listed Miscellaneous conditions.

15. Has any applicant, in the last 12 months, taken or been prescribed any prescription drug, whether or not taken, including refills, for any illness or condition? Yes No

16. Has any applicant, in the last 5 years, had any symptoms, or consulted with, received medical advice from, been diagnosed, treated, or prescribed any medication by a member of the medical profession for any condition or illness not listed above? Yes No

17. Has any applicant, in the last 12 months, consulted a physician for a physical examination or check up, been treated in an emergency room or care setting or been hospitalized for any reason? Yes No
If yes, please provide details, results and describe what medical advice was given and what treatment was recommended _____

18. Has any applicant, in the last 12 months, been exposed to hazardous materials, including, but not limited to asbestos or toxic chemicals?..... Yes No

F. Medical History Details

Please supply complete details for answers to questions in section E. If additional space is needed, please use the Supplement to Application Form or a separate sheet of paper. Please sign and date such attachments.

Question No. (e.g. 14A)	Name of Person Treated	Dates of Treatment From To Mo/Yr Mo/Yr	Name of Condition and Diagnosis (Explain Treatment including hospitalizations, surgery and results of any tests)	Name of Drugs & Dosage Prescribed, If Any	Degree of Recovery (Full Recovery or Ongoing)	Treating Physician's Name, Address and Phone Number

G. Prior Carrier Information

Are or were you or any of your dependents applying for this insurance, covered under another health insurance benefit plan, excluding short term medical insurance, within the last 90 days? Yes No If yes, please list person(s) covered: _____

Name and phone number of current/prior health insurance carrier: _____

Policy # _____ Effective date of coverage _____ Paid-to-date of coverage listed or expected termination date _____

Is/was current/prior health insurance coverage provided by an employer? Yes No

Failure to disclose complete prior carrier information may result in a delay of processing your application.

H. Health Insurance Portability and Accountability Act (HIPAA)

Federal law provides for waiving of pre-existing conditions limitation period for qualified persons applying under HIPAA. HIPAA qualified individuals must meet all of the following criteria: • must have 18 months of continuous creditable coverage • most recent coverage must be a group, governmental or church plan, or an individual plan issued in FL by a health insurer or HMO which coverage is terminated due to the insurer or HMO becoming insolvent or discontinuing the offering of all individual coverage in the State of FL, or due to the insured no longer living in the service area in the State of Florida of the insurer or HMO that provides coverage through a network plan in the State of FL • must not be eligible for group coverage, medicare or medicaid • cannot have other health insurance coverage • must have elected and exhausted any COBRA or state continuation coverage • most recent coverage must not have terminated due to premium lapse or fraud. Persons residing in the following states who desire to obtain coverage under HIPAA must apply through the state's alternative mechanism. Guarantee Trust **WILL NOT** accept HIPAA applicants in these states: AL, AK, AR, CO, CT, GA, IL, IN, IA, KS, KY, LA, MI, MN, MS, MT, NE, NM, ND, OK, OR, PA, SC, TX, WI, or WY.

Do you or any dependent desire to apply under HIPAA? Yes No If yes, who? _____

If yes, complete and submit the HIPAA Eligibility Questionnaire. Additional premium is required. All questions on the application must be completed.

Your responses to health and avocation questions will not be used to determine HIPAA eligibility.

I. Certification and Signature

By signing below:

I have reviewed and understand the Policy's benefits, limitations and exclusions including the **Pre-existing Condition limitation** provision. I understand that the coverage for each applicant, if issued, will be subject to a **pre-existing condition limitation** for up to 2 years unless the medical condition is disclosed in the Medical History section of this application and not specifically excluded by name from coverage under the certificate.

I understand that I must be a member of ABP Association to be eligible for this insurance. I understand that this insurance is not designed nor marketed as employer provided insurance. This coverage does not comply with the small employer group laws of my state of residence. Therefore, this plan cannot be used, now or in the future, by me or an employer to provide insurance for employees. I certify that: a. no portion of the premium will be paid initially or during the period the coverage is in force, by or on behalf of my employer, either directly, or through wage adjustments or other means of reimbursement; b. neither I nor my dependents intend to treat this insurance as part of a plan or program under section 106, 125 or 162 (except 162(l)) of the US Internal Revenue code; and c. this plan was not marketed through my employer's place of business.

I certify all statements contained herein and on any attachments or amendments are true, complete, and correct and that no material information has been withheld or omitted. Furthermore, **I UNDERSTAND THAT:**

- Guarantee Trust Life Insurance Company (Insurer) will individually underwrite my application;
- The responses contained herein and on any attachments or amendments will be relied upon by the Insurer in the issuance of insurance coverage;
- Any incomplete, incorrect or misleading answers or misrepresentation of material facts on this application may give the Insurer the right to deny benefits, rescind insurance, add an exclusion endorsement rider, or increase the premium payable for coverage under the policy, in accordance with the provisions of the certificate for which I am applying;
- No agent has authority to advise me to omit or inaccurately report any information requested herein and I represent that such has not occurred;
- No representation by an agent or any other person shall be binding on the Insurer unless the representation is reduced to writing and signed by an officer of the insurer;
- The insurance hereby applied for will not be considered in force until an insurance certificate is issued and full first premium paid while I am alive and in good health and other conditions remain as described in this application. No insurance will be effective until the date specified by the Insurer in the certificate. The actual effective date may not be the requested effective date;
- I must tell the Insurer or its Administrator if my health condition or the health condition of any dependent applicant changes between the date this application is signed and the date I receive written notification of approval, providing coverage is approved by the Insurer;
- Insurer only reviews medical records in determining whether to issue coverage when, in Insurer's sole discretion, Insurer believes it is necessary or desirable to review such records;
- If this application is declined or withdrawn or if an insurance certificate is not issued or accepted, the only obligation of Insurer will be to return any premium paid. **The nonrefundable processing fee, if any, will not be returned.**
- This application shall be deemed to have been declined if it has not been approved by the Insurer within 60 days of the date of the application.
- I understand that an electronic signature on this application and/or any Endorsement Riders is legal and enforceable.

X _____	_____	_____
Signature of Applicant (or parent if applicant is under age 18)	Date	City, State
X _____	_____	_____
Signature of Spouse (if applying)	Date	City, State
X _____	_____	_____
Signature of Dependent Over 18 (if applying)	Date	City, State
X _____	_____	_____
Signature of Dependent Over 18 (if applying)	Date	City, State

Any person who, knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing false, incomplete, or misleading information is guilty of a felony of the third degree.

THIS POLICY IS PRIMARILY GOVERNED BY THE LAWS OF ILLINOIS. AS A RESULT, ALL OF THE RATING LAWS APPLICABLE TO POLICIES FILED IN THIS STATE DO NOT APPLY TO THIS COVERAGE, WHICH MAY RESULT IN INCREASES IN YOUR PREMIUM AT RENEWAL THAT WOULD NOT BE PERMISSIBLE UNDER A FLORIDA-APPROVED POLICY. ANY PURCHASE OF INDIVIDUAL HEALTH INSURANCE SHOULD BE CONSIDERED CAREFULLY, AS FUTURE MEDICAL CONDITIONS MAY MAKE IT IMPOSSIBLE TO QUALIFY FOR ANOTHER INDIVIDUAL HEALTH POLICY. FOR INFORMATION CONCERNING INDIVIDUAL HEALTH COVERAGE UNDER A FLORIDA-APPROVED POLICY, CONSULT YOUR AGENT OR THE FLORIDA DEPARTMENT OF FINANCIAL SERVICES.

J. Producing Agent Information and Statement

Producing Agent's Name (please print) _____ Agency Name _____

Producing Agent's GA or MGA Name (please print) _____ Producer Agent No. _____

Street Address _____ City _____ State _____ Zip _____

Daytime Phone Number (____) _____ Fax Number (____) _____ E-Mail Address _____

I certify the following statements are true and complete: • that the application was completely filled out by the applicant, or I have truly, accurately and completely recorded all the information given to me by the applicant and the applicant has personally reviewed the completed application; • I know of no other medical information about those persons applying for coverage other than that contained on this application; • I have explained all the policy benefits, exclusions, limitations as well as additional out-of-pocket costs if a non-PPO provider is used under the PPO Plans; • I have not advised the applicant to omit or inaccurately report any information requested on the application or on any attachments or amendments, and I represent that such has not occurred; • I understand I have no right to bind coverage and I have advised the applicant that no insurance will be effective unless approved in writing by the Insurer and have instructed the applicant not to terminate any existing health insurance coverage prior to receiving the Insurer's written notice of approval.

Producing Agent's Signature **X** _____ Florida License ID Number _____ Date _____

Type of Sale: In Person Phone On-Line

GUARANTEE TRUST LIFE INSURANCE COMPANY
AUTHORIZATION FOR THE RELEASE OF MEDICAL RECORDS
for Enrollment/Eligibility for Benefits Determinations

I authorize any and all physicians, medical practitioners, hospitals, clinics, medical or medically-related facilities, health plans, pharmacy benefit managers, pharmacies or pharmacy-related facilities; health care providers, MIB Group, Inc., MIB, Inc. (MIB), e-nable Corporation, IntelRx, LLC, insurance companies and their business associates and those persons or entities providing services to the insurers' business associates which are related in any way to their insurance plans to disclose my health information and the health information of my minor dependents. This specifically includes the release of all medical records including without limitation those containing information relating to diagnoses, treatments, consultation, care, advice, laboratory or diagnostic tests, physical examinations, recommendations for future care, prescription drug information, alcohol or drug abuse, mental illness or information regarding communicable or infectious conditions, such as HIV and/or AIDS. However, this authorization does not include use or disclosure of "psychotherapy notes". Medication prescription and monitoring, counseling session start and stop times, the modalities and frequencies of treatment furnished, results of clinical tests, and any summary of the following: diagnosis, functional status, the treatment plan, symptoms, prognosis, and progress to date are not considered "psychotherapy notes".

Guarantee Trust Life Insurance Company and its business associates (specifically including, but not limited to, **Insurers Administrative Corporation (IAC)** and those persons or entities providing services to Guarantee Trust Life's business associates (specifically including **Management Research Services, Inc. (MRS)** and **Executive Management Services, Inc. (EMSI)**) which are related in any way to Guarantee Trust Life's health plans are authorized to receive and use my health information to make enrollment/eligibility for benefit determinations, specifically including, but not limited to, underwriting and risk rating determinations. If coverage is issued, such determinations may include determinations as to whether coverage should be rescinded or reformed if I have made any omission(s) or misrepresentation(s) in my application which are material to the underwriting process.

I understand that if I refuse to sign this authorization, my application for insurance with Guarantee Trust Life Insurance Company will be rejected. I also understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on this authorization or the insurance company exercises a legal right to contest a claim or the policy itself, by sending a written revocation to Guarantee Trust Life Insurance Company, c/o Privacy Officer, 1275 Milwaukee Avenue, Glenview, IL 60025.

This authorization will expire 24 months after the date signed. This authorization revokes any previous restrictions concerning access to such information. **A copy of this authorization is as valid as the original. I understand that, if done, my electronic signature to this form operates as my original signature. This electronic signature fully complies with the Federal Electronic Signature statute, Title 15, U.S.C., Chap. 96, Sec. 7001, es. seq., and is therefore fully legal and valid as an original signature.**

Notification Regarding the Medical Information Bureau

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 the Medical Information Bureau (MIB), a not-for-profit membership organization of insurance companies, which operates an information exchange on behalf of its members. If you apply to another Bureau member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901 (TTY (866) 346-3642). If you question the accuracy of the information in the MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112. Guarantee Trust Life Insurance Company or its reinsurers may also release information in its file 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.

I/We, the undersigned, hereby request and authorize:

Name: _____

Address: _____

to release the specified information from my records.

Signature of each Individual over Age 18 (and Parent or guardian on behalf of any minor dependent to be covered):

	Signature	Birthplace (State/Country)	Soc. Sec. No.	Date
Applicant	_____	_____	_____	_____
Spouse (if applying)	_____	_____	_____	_____
Dependent over 18 (if applying)	_____	_____	_____	_____
Dependent over 18 (if applying)	_____	_____	_____	_____

You must complete the following if applying for coverage for a minor dependent:

Please check the appropriate box if you are signing for one or more minor dependents:

- Parent Legal Guardian Trustee (If trustee or legal guardian, please supply legal documentation)

PRE-AUTHORIZED CHECKING PLAN PAYMENT OPTION

Guarantee Trust Life Insurance Company, or its designated administrator, is hereby authorized to debit my checking or savings account until this authorization is terminated. I understand that: • the non-refundable processing fee will be debited/deposited upon receipt of the application; • the balance of the total initial amount due will be debited upon **(must check one)**: receipt of the application, issuance of the certificate/policy if issued prior to the requested effective date, or the effective date of the certificate/policy if later than the policy issue date; • **if no option is checked, the balance of the initial total premium will be debited upon issuance of the certificate/policy**; • after the total initial deposit or debit, all subsequent debits will be made on the first or fifteenth of the month to coincide with the effective date; • the non-refundable processing fee will not be returned; • if the application is declined or withdrawn only the premiums paid will be refunded; • if the coverage is issued no premium will be refunded after the Right to Examine period. I further authorize the bank named below to pay the charge to my account those payments that are drawn on my account by Guarantee Trust Life Insurance Company, and I agree that the bank named below shall be fully protected in honoring any such payments. The bank's rights and treatment of each payment shall be the same as if it were signed by me. If any such payment is dishonored, whether with or without cause, I understand that the bank shall not be liable whatsoever, even though such dishonor results in a forfeiture of insurance. The authorization above remains in effect until the bank is notified of termination by me in writing. To terminate coverage, I will also notify Guarantee Trust Life Insurance Company in writing.

Signature of Account Holder **X** _____ Date _____

Name (please print) _____ Relationship to Applicant _____

Name of Bank _____ Address _____

Checking Account Number _____ Bank Routing Number _____

Savings Account Number _____ *Coverage purchased by check is subject to clearance of the check.*

CREDIT CARD PAYMENT AUTHORIZATION IF PAYING VIA CREDIT CARD

Visa Master Card I authorize Guarantee Trust Life Insurance Company or its administrator to debit my Visa or Master Card for the Total Initial Amount due and subsequent payments due. I understand that: • the non-refundable processing fee will be debited upon receipt of the application; • the balance of the total initial amount due will be debited upon **(must check one)**: receipt of the application, issuance of the certificate/policy if issued prior to the requested effective date, or the effective date of the certificate/policy if later than the policy issue date; • **if no option is checked, the balance of the initial total premium will be debited upon issuance of the certificate/policy**; • after the total initial deposit or debit, all subsequent debits will be made on the first or fifteenth of the month to coincide with the effective date; • the non-refundable processing fee will not be returned; • if the application is declined or withdrawn only the premiums paid will be refunded; • if the coverage is issued no premium will be refunded after the Right to Examine period. Payment by credit card is subject to acceptance of the credit card issuer and clearance of the debit.

Cardholder Name _____ Cardholder Signature _____

Account No. _____ Expiration Date ____/____/____

AMERIBENEFIT PLAN (ABP) ASSOCIATION MEMBERSHIP ENROLLMENT FORM

Please enroll me as a member of the AmeriBenefit Plan Association. I elect the following membership plan:

\$1,000 - (\$27.50/mo.) **\$5,000** - (\$37.50/mo.)

My membership entitles me to all the money saving Association benefits applicable to the plan I elect. I understand that my monthly membership dues will be collected by mode selected. **Application for Group Major Medical Insurance is only available to ABP Members.**

Name _____ Male Female Home Phone (____) _____

Address _____ City _____ State _____ Zip _____

Applicant's Signature **X** _____ Date _____

AmeriBenefit Plan, Membership Services Office, 16476 Chesterfield Airport Road, Chesterfield, MO 63017

HELPFUL HINTS AND REMINDERS

1. Processing the application will be delayed if the following information is missing:
 - If paying monthly direct, quarterly or semi annually , initial premium check payable to Guarantee Trust Life Insurance Company
 - Plan selected, as well as any optional benefits and desired PPO network if PPO plan selected
 - Medical History Details to health questions answered "yes"
 - Applicant(s) signatures
 - Initials on strikethroughs or overwrites or use of white out
 - ABP enrollment form missing applicant signature
 - Producing Agent information
2. Underwriting process may be expedited if an Attending Physician Statement (APS) and/or Doctor's records are included with Doctor's Statement certifying number of pages.
3. All underwriting correspondence is mailed to the applicant and a copy sent to the writing agent. Please allow at least 30 days processing time if an APS is being requested.
4. Explain the COST SAVINGS associated when using a PPO provider. Explain the ADDITIONAL COST associated with using a non-PPO provider on PPO plans.
5. Copy of rating software quote provided to the applicant must be included with the submitted application.
6. **If not applying online, ALL APPLICATIONS MUST BE SENT DIRECTLY TO YOUR MANAGER.**

Never advise or permit an individual to omit reporting current or past medical history, conditions, doctors visits, tests (whether completed or recommended), or medications. Providing the applicant's physician's name and address does not mean that records will automatically be requested. Medical records will only be requested if required by Underwriting.