

APPLICATION FOR LIFE INSURANCE TO: GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue - Glenview, Illinois 60025

1a. Proposed Insured (P.I.) #1	Social Security #	Sex	Birth Date	Age	Birthplace	Height	Weight
(First, Middle & Last)			Mo. Day Yr.				

Occupation _____ Duties _____ Length of Current Employment _____

Primary Beneficiary _____ Relationship _____ Contingent Beneficiary _____ Relationship _____

1b. Proposed Insured (P.I.) #2	Social Security#	Sex	Birth Date	Age	Birthplace	Height	Weight
(First, Middle & Last)			Mo. Day Yr.				

Occupation _____ Duties _____ Length of Current Employment _____

Primary Beneficiary _____ Relationship _____ Contingent Beneficiary _____ Relationship _____

1c. Address (Street, City, State & Zip Code)

E-Mail Address _____

Phone Number: Home () _____ Work () _____

2. Select Plan Coverage:

Proposed Insured #1	Plan Applied For: <input type="checkbox"/> 10 Year Term Life Policy with Full Accelerated Benefit Coverage <input type="checkbox"/> 10 Year Term Life Policy with Limited Accelerated Benefit Coverage <input type="checkbox"/> 20 Year Term Life Policy with Full Accelerated Benefit Coverage* <input type="checkbox"/> 20 Year Term Life Policy with Limited Accelerated Benefit Coverage* <i>*Term to 70 for ages 51-60</i> Face Amount \$ _____ <input type="checkbox"/> Money Purchase \$ _____ <i>(For Proposed Insured under age 20, Face Amount is \$5,000 or \$10,000 only)</i>	Optional Benefit Riders: <input type="checkbox"/> Accidental Death Benefit Rider <i>(Available for ages 20 and over)</i> <input type="checkbox"/> Waiver of Premium Rider <i>(Available for ages 20 and over)</i> <input type="checkbox"/> Return of Premium Rider <i>(Available with 20 Year Term Plan only and for ages 0-50)</i>
	Proposed Insured #2	Plan Applied For: <input type="checkbox"/> 10 Year Term Life Policy with Full Accelerated Benefit Coverage <input type="checkbox"/> 10 Year Term Life Policy with Limited Accelerated Benefit Coverage <input type="checkbox"/> 20 Year Term Life Policy with Full Accelerated Benefit Coverage* <input type="checkbox"/> 20 Year Term Life Policy with Limited Accelerated Benefit Coverage* <i>* Term to 70 for ages 51-60</i> Face Amount \$ _____ <input type="checkbox"/> Money Purchase \$ _____ <i>(For Proposed Insured under age 20, Face Amount is \$5,000 or \$10,000 only)</i>

3. Billing Information: Amount of Premium Collected: PI #1 \$ _____ PI #2 \$ _____

Premium Mode: Annual Semi-Annual Quarterly Monthly PAC List Bill Monthly

Mail Premium Notices to: Owner Premium Payor Group Number _____

Owner (if other than Proposed Insured):

Name _____ Relationship _____

Address _____ Social Security Number _____

Premium Payor (if other than Proposed Insured):

Name _____ Relationship _____

Address _____

4. Will this policy applied for replace or change any existing life insurance or annuity in force? Yes No Yes No
 If yes, please give details and submit any required replacement forms.

If the answer to any part of questions 5a-9 is "Yes," that proposed insured does not qualify for this plan.

	Proposed Insured	
	#1	#2
<p>5. In the past 10 years, has anyone proposed for insurance had, been told they had, received treatment or medical advice by a medical practitioner for any of the following conditions:</p> <p>(a) Leukemia, malignant melanoma, lymphoma, sarcoma, or any other type of cancer (excluding skin cancer) or any tumor of the brain?</p> <p>(b) Disease of the heart or heart valves, heart attack, coronary bypass, angioplasty, stent placement, angina, heart arrhythmia requiring treatment, cardiomyopathy, congenital heart defect, abnormal heart test or high blood pressure requiring the use of 3 or more medications?</p> <p>(c) Stroke, Transient Ischemic Attack (TIA), peripheral vascular disease, aneurysm, brain hemorrhage, anemia (other than iron deficiency), major organ transplant or diabetes treated with insulin, or diabetes diagnosed before age 35 or diabetes diagnosed over 10 years ago?</p> <p>(d) Optic neuritis, macular degeneration, Parkinson's disease, paralysis, dementia, Alzheimer's disease, mental retardation, multiple sclerosis, muscular dystrophy, Huntington's disease, Motor Neuron disease, cystic fibrosis or cerebral palsy?</p> <p>(e) Chronic kidney, liver, respiratory or lung disease, schizophrenia or other psychosis, chronic depression, scleroderma, systemic lupus erythematosus, ulcerative colitis or Crohn's disease?</p> <p>(f) Acquired Immune Deficiency (AIDS) or AIDS Related Complex (ARC) or tested positive for the HIV virus?</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p>6. In the past 5 years has anyone proposed for insurance been treated for drug or alcohol abuse or abused alcohol or drugs or had abnormal test results relating to alcohol or drug use or been convicted of a felony or had your license revoked or suspended?</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p>7. In the past 5 years has anyone proposed for insurance participated or plan to participate in mountain climbing, hang gliding, parachuting, water or land racing, or flown as a private pilot or crew member?</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p>8. In the past 12 months has anyone proposed for insurance had any abnormal diagnostic test results, awaiting test results, or been advised to have any diagnostic test (including self-administered), or had a medical condition, symptom or abnormality for which you have not yet sought medical treatment or advice?</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p>9. For anyone proposed for Insurance, did 2 or more of your natural parent(s), sister(s), brother(s), either living or dead suffer from diabetes, cancer, stroke, heart disease, kidney disease, paralysis or any hereditary disease before the age of 60?</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p>10. During the past 12 months has anyone proposed for insurance used any tobacco products?</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>
<p>11. Is any person proposed for insurance taking any prescription medication? If yes please list below</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>	<p><input type="checkbox"/>Yes <input type="checkbox"/>No</p>

Name of Person	Name of Medication(s)	Reason for Medication (s)	Dosage

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 Savings Account

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 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 obtain 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 obtain 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 the 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 not-for-profit membership organization of life 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, the MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request form from you, the MIB, Inc. will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB, Inc.'s file, you may contact them and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. You may contact the MIB, Inc. at 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/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	



Temporary Life Insurance and Premium Receipt

PLEASE READ THIS RECEIPT CAREFULLY!

Received from _____ this _____ day of _____, _____ \$ _____ by check, preauthorized order for withdrawal, or salary deduction plan. This payment is the amount of the first full modal premium for the policy applied for in the application for life insurance to Guarantee Trust Life Insurance Company ('GTL' hereafter). This payment is made and accepted under the terms of this Receipt. This Receipt cannot be transferred. ANY PAYMENT BY CHECK MUST BE MADE PAYABLE TO GUARANTEE TRUST LIFE INSURANCE COMPANY. DO NOT MAKE ANY CHECK PAYABLE TO THE AGENT OR LEAVE THE PAYEE BLANK. If your check or draft is not honored when first presented for payment, this Receipt will not be valid.

Effective with the date that the premium is accepted, and subject to the terms and conditions stated below, the amount of insurance applied for shall take effect for death as a result of accidental or natural causes originating after the date of this application.

The Company's liability for insurance under this Receipt on any proposed insured is limited to the lesser of: (1) the amount applied for in the application; or (2) \$100,000, less any coverage in force including coverage provided under any other Temporary Insurance Agreement and receipts with GTL.

Any Insurance in effect because of this Receipt will end at the earliest of: (1) the date the application is approved; or (2) if the application is disapproved, after both a) the Company has provided written notice to the applicant of an adverse underwriting decision, and b) the premium paid for the coverage is refunded.

When an application for an individual life insurance policy and an initial premium has been received, a written receipt for the premium shall be provided and will; (1) Exclude coverage if the proposed insured commits suicide; (2) void coverage if the application contains material misrepresentation or is fraudulently completed; (3) limit the coverage otherwise provided by specifying for each proposed insured the amount and type of temporary coverage granted; and (4) void coverage if a check or draft received in payment of the premium is not honored for payment when presented.

I acknowledge possession of this Receipt. I certify that I have read it and the terms of the application. I also certify that the agent has explained the terms and conditions of this Receipt and the terms in the application to me and that I understand and accept them. No agent of the Company and no broker is allowed to change or waive any of these terms.

Signed at _____ this _____ day of _____, _____

Agent's Signature

Signature of Applicant

Guarantee Trust life Insurance Company • 1275 Milwaukee Avenue, Glenview, Illinois 60025 • www.gtlic.com • Tel: 847-699-0600