GTL's Home Alliance Client Profile Worksheet and Application

Important: Sections 1 and 5 must be completed and submitted with the application.

Section 1: Client Personal Information

Name ______________________ **Age**________ Spouse ______________________ **Age** ________

Sex: ☐ **Male** ☐ **Female** **Smoker:** ☐ **Yes** ☐ **No** **Sex:** ☐ **Male** ☐ **Female** **Smoker:** ☐ **Yes** ☐ **No**

Date Mortgage applied for or refinanced_____/_____/____

First Mortgage Balance $ ____________________ **First Mortgage Payment $** ____________________

Second Mortgage Balance $____________________ **Second Mortgage Payment $** ____________________

Section 2: Personal Needs Analysis - Base Plan Type

Desired Face Amount: $___________

☐ Level 10 year **(Ages 20 – 60)**
☐ Level 15 year **(Ages 20 – 55)**
☐ Level 20 year **(Ages 20 – 50)**
☐ Level 30 year **(Ages 20 – 40)**
☐ Decreasing Term 30 year **(Ages 20 – 40)**
☐ 30 year Term / 20 year level **(Ages 20 – 45)**

Section 3: Personal Needs Analysis – Additional Coverage Options

Value the importance of each additional coverage option below by checking the appropriate box.

	Very Important	Somewhat Important	Not Important
Accidental Death Benefit Rider	☐	☐	☐
Spouse Insurance Rider	☐	☐	☐
Children's Insurance Rider	☐	☐	☐
Waiver of Premium Rider	☐	☐	☐
Return of Premium Rider	☐	☐	☐

Section 4: Design Your Own Plan

Fill-in the cost of the base plan and each additional coverage option desired.

Base Plan $__________
Accidental Death Benefit $__________
Spouse Insurance $__________
Children's Insurance $__________
Waiver of Premium $__________
Return of Premium $__________
Policy Fee $_____60.00

Modal Factors: Semi-Annual = 0.51
Quarterly = 0.26
Monthly Bank Draft = 0.087

Total Annual Premium $__________ X __________ (Modal Factor) = $ ______________ (Modal Premium)

Section 5: Applicant Signature

Applicant Signature: ________________________

GTL's Home Alliance is a level or decreasing term life insurance plan issued by Guarantee Trust Life Insurance Company, Glenview, IL. Premiums and death benefit are guaranteed for the term period chosen. All plans and riders may not be available in all states. For agent use only.

Application for Life Insurance to: GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Ave. ■ Glenview, Illinois 60025

APPLICATION FOR: ❑ NEW COVERAGE ❑ REINSTATEMENT

PROPOSED INSURED

1. Proposed Insured (Print first name, middle initial, and last name)	Sex	Date of Birth Mo./Day/Yr.	Age	Country of birth	Height Ft. In.	Weight in lbs.	Social Security #

2. Home Address ______________________________
Number and Street City State Zip Code
Home Phone Number (_______)______________ Business Phone Number (________)______________

PLAN AND BILLING

3A. **Proposed Insured**
Base Plan Face Amount __________________
❑ 10 Year Level Term ❑ 20 Year Level Term
❑ 15 Year Level Term ❑ 30 Year Decreasing Term

Proposed Insured
Optional Riders
❑ Accidental Death Benefit Rider
❑ Waiver of Premium Rider

3B. **Spouse Optional Rider** ❑ Renewable and ConvertibleTerm Rider - Amount:______________________

Name (First, Middle, Last) Relationship Sex Date of Birth Age Country of Birth Height Weight Social Security #

3C. **Children Optional Rider** ❑ Children's Term Rider - Unit:____________________________

Name of Children (first , middle initial, last)	Relationship	Sex	Date of Birth	Age	Country of Birth	Height Ft. In.	Weight In lbs.	Social Security #

Premium Mode: ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ Monthly Bank Draft Premium Collected $_____________

4. Request Policy Date of: ________________________ Request Draft Date of: ________________________
5. Send Billing & Correspondence to: ❑ Insured ❑ Owner ❑ Payer 7. Soc. Sec. Number for Owner/Payer:______________
Name & Address of Owner/Payer (if other than Proposed Insured): ______________________________
Address: ______________________________ Relationship: ______________________
6. **Beneficiary:** Primary: ______________________________ Relationship ______________________
Contingent: ______________________________ Relationship ______________________
Contingent: ______________________________ Relationship ______________________

UNDERWRITING

7. Has any person proposed for insurance used any tobacco products in the past 12 months?………….…………………..❑ Yes ❑ No
8. Has any person proposed for insurance ever been declined, restricted, rated up, or postponed for any kind of life and/or disability insurance?……………………………………………………………………………………………..❑ Yes ❑ No
9. Has any person proposed for insurance, in the past five years, made or now contemplate making flights as a pilot, student pilot, crewmember, or observer or participated in or plan to participate in skydiving, parachuting, hang gliding, underwater diving, organized racing, or any other hazardous sport? If yes, complete and submit Avocation Questionnaire…❑ Yes ❑ No
10. Has any person proposed for insurance had their driver's license suspended, revoked, or been charged with a "DUI" within the last three years?…………… ……………………………………………………………………………………❑ Yes ❑ No
If yes, please list that/those person's driver's license number(s): ______________________________
11. Has any person proposed for insurance been convicted of a felony or is any person proposed for insurance currently on probation or parole?…………………………………………………………………………………………. ❑ Yes ❑ No
12. Is any person proposed for insurance not a United States citizen or legal alien resident of the United States?…….……❑ Yes ❑ No
13. Please give the complete details for questions 7–12 answered "Yes." Include applicable name(s) and item number(s) below:

____
____
____

OTHER INSURANCE

14. Does any person proposed for insurance currently have in-force, applied for or insurance now pending or contemplated for:
    Life insurance?.. ❑ Yes ❑ No
    If yes, give complete details ____
    ____
    ____

15. Will this coverage applied for replace or change any life insurance currently in force? .... ❑ Yes ❑ No
    If "Yes," please list name of the person proposed for insurance, policy number, face amount of insurance, and/or benefit amount of the policy being replaced; also provide the Company name and submit necessary replacement forms. ______________________________
    ____
    ____
    ____

MEDICAL INFORMATION

16. To the best of your knowledge and belief, has any person proposed for insurance had, been diagnosed as having, been advised to seek treatment for, or been treated by a medical practitioner within the past 10 years for any of the following (circle the appropriate condition for each "Yes" answer):
    a. Asthma, emphysema, bronchitis, chronic obstructive lung disease, or other disease of the respiratory system?...... ❑ Yes ❑ No
    b. High blood pressure, stroke, heart attack, congestive heart failure, heart or blood vessel surgery or procedure, peripheral vascular disease, heart murmur, chest pain or angina, or other disease of the cardiovascular system?.... ❑ Yes ❑ No
    c. Disease of the liver, kidney, bladder, pancreas, stomach or intestine?... ❑ Yes ❑ No
    d. Paralysis, convulsions, epilepsy, anxiety, depression, psychosis, or other mental or nervous disorder of the brain or nervous system or problems with memory?.. ❑ Yes ❑ No
    e. Back problems or back or knee sprain or strain, arthritis, fractures, joint disease or replacement or disease of the muscular or skeletal system or connective tissue disorder?.. ❑ Yes ❑ No
    f. Protein, sugar, blood or pus in the urine, disorder of the prostate, breast or reproductive organs, or internal or skin cancer, melanoma, leukemia, or tumor? .... ❑ Yes ❑ No
    g. Diabetes, or disease of the pituitary, adrenal, or thyroid gland or collagen disease? .... ❑ Yes ❑ No
    h. Alcohol or drug use, or used drugs, such as heroin, cocaine, amphetamines, or other narcotics not prescribed by a doctor?.. ❑ Yes ❑ No
17. In the past 10 years have you been 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
18. Has any person proposed for insurance within the past 5 years, consulted or been treated by a member of the medical profession for a condition other than previously stated above or been advised to have surgery not yet completed?......❑ Yes ❑ No
19. Has any person proposed for insurance currently taking any prescription medication(s) or been advised to take any medication(s)?.. ❑ Yes ❑ No
20. Please give complete details to any "Yes" answers for question 16a-h and questions 17 - 19. Include names, addresses, and phone numbers for doctors, and dates and reasons for treatment. Be sure to indicate the person proposed for insurance to which the "Yes" answer applies, and the question number(s): ____
    ____
    ____
    ____
    ____
    ____

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

AUTHORIZATION

I understand and agree that Guarantee Trust Life Insurance Company, its reinsurers, insurance support organizations, and their authorized representatives may obtain medical, criminal and driving records in order to evaluate my application for insurance. I authorize any doctor, medical practitioner, hospital, clinic, or other medical care facility, insurance company, the Medical Information Bureau, Inc., or employer, having information of medical care, advice or treatment about any physical or mental condition regarding me or my family members named in this application, to give the information to Guarantee Trust Life Insurance Company or its reinsurers. This authorization includes information about drugs, alcoholism, or mental illness or employment or other insurance. I authorize all sources, except the Medical Information Bureau Inc. to give such records to any agency employed by Guarantee Trust Life Insurance Company to collect such information. This authorization will be valid from the date signed for a period of two and one-half years. I agree a photographic copy of this authorization shall be as valid as the original. I have read this authorization and understand that I or my authorized representative is entitled to receive a copy of the form. I have also received 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 in your state).

ACKNOWLEDGEMENTS: The Proposed Insured represents and agrees as follows: 1) That the statements contained in the application concerning past and present health are complete, true, and correct. 2) Any insurance 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 this application will not take effect unless and until the full first premium is paid and the policy is delivered during such person's lifetime and while such person is in the condition of health set forth in this application. 5) Provisions concerning exceptions, exclusions, limitations, and renewal in the insurance which has been applied for, have been explained and are understood.

CAUTION: If your answers on this application are incorrect or untrue, Guarantee Trust Life Insurance Company has the right to deny benefits or rescind your coverage.

X____
Signature of Proposed Insured Date

X____
Signature of Applicant/Owner (if other than Proposed Insured) Date

X____
Signature of Spouse (Insured under Renewable and Convertible Term Rider)

Application Signed/Dated in: ______________________________
City State

I have witnessed the signature of the Applicant and the Proposed Insured, if different. I certify that I asked all the questions and truly and accurately recorded the answers contained herein. To the best of my knowledge and belief, the insurance applied for: ☐ is or is likely, ☐ is not or is not likely to replace or change any existing policy(ies) or contract(s).

X____
Signature of Soliciting Agent & Agent Code Number Print Name of Agent Florida License I.D. No. Agent's Telephone Number Date

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
1-800-635-1993

HIPAA AUTHORIZATION

To Permit Use and Disclosure of Health Information

By signing this form, I (we) 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 (our) physical condition, other coverage and any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from the Medical Information Bureau. This Authorization includes all information about drugs, alcoholism, and mental illness. I (we) understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. I (we) agree that this Authorization will be valid for 24 months from the date signed, and know that I (we) or my (our) authorized representative may have a photocopy of it. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below.

I (we) understand that I (we) have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I (we) 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 (our) agent or to the attention of the Underwriting Manager.

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

____
(Print Please) Name of Applicant

____
Signature of Applicant and Date

____
(Please Print) Name of Authorized Representative, or Next of Kin

____
Relationship of Authorized Representative or Next of Kin to Patient

____
Signature of Authorized Representative or Next of Kin and Date

1 Copy to Agent, 1 Copy to Applicant

GUARANTEE TRUST LIFE INSURANCE COMPANY

MONTHLY PRE-AUTHORIZED PREMIUM PAYMENT PLAN

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

TO ____

Name of my Bank | My Bank's Address | City | State | Zip Code

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

Account #: ______________________ Bank Routing #: ______________________

Account Type: ❑ Checking Account *(Attach a Voided "Sample" check)* ❑ Savings Account *(Attach a Voided "Sample" check) if applicable, or a Deposit slip*

I agree that my rights in respect to each payment shall be the same is if it were drawn by me and signed personally by me. This authority is to remain in effect until revoked by me in writing and until you receive notice for which you agree you will be fully protected in honoring such requests. I 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 covering your health, job and financial situation, as well as your character, general reputation and mode of living. We will not collect information relating to your sexual orientation.

The personal information we obtain about you is treated as confidential and will not be disclosed to other persons or organizations without your written authorization except to the extent necessary, as permitted by law, for the conduct of our business. But any information collected by a "consumer reporting agency" may be shared by the agency with others who use such information, but only to the extent which the Fair Credit Reporting Act permits.

You have a right of access, and right of correction, concerning recorded personal information obtained in our file. In order to exercise these rights, you must contact us in writing requesting access or correction. You have no access right to privileged information. If we 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 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, a non-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 Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address to the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. 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 an 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