

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 30 year (Ages 20 – 40)
 Level 15 year (Ages 20 – 55) Decreasing Term 30 year (Ages 20 – 40)
 Level 20 year (Ages 20 – 50) 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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Spouse Insurance Rider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Children's Insurance Rider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waiver of Premium Rider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Return of Premium Rider	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

Section 4: Design Your Own Plan

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

Base Plan	\$ _____	Modal Factors: Semi-Annual	= 0.51
Accidental Death Benefit	\$ _____	Quarterly	= 0.26
Spouse Insurance	\$ _____	Monthly Bank Draft	= 0.087
Children's Insurance	\$ _____		
Waiver of Premium	\$ _____		
Return of Premium	\$ _____		
Policy Fee	\$ <u>60.00</u>		

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: 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 _____ <input type="checkbox"/> 10 Year Level Term <input type="checkbox"/> 30 Year Level Term <input type="checkbox"/> 15 Year Level Term <input type="checkbox"/> 30 Year Decreasing Term <input type="checkbox"/> 20 Year Level Term <input type="checkbox"/> 30 Year Term (20 yr. level/10 yr. indeterminate premium)	Proposed Insured Optional Riders <input type="checkbox"/> Accidental Death Benefit Rider <input type="checkbox"/> Waiver of Premium Rider <input type="checkbox"/> Return of Premium Rider
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3B. Spouse Optional Rider Renewable and Convertible Term 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 Certificate 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 _____

EMPLOYMENT INFORMATION

7a. Has Proposed Insured been gainfully employed (at least 30 hours per week) for the past 12 months? Yes No
 If no, please give details: _____
 b. Describe occupation and duties: _____
 c. Employer: _____
 Name _____ Address _____ Phone Number _____
 d. Provide details of prior occupation if working in present occupation less than 1 year _____
 e. Actual Earned Income? _____ (Business owners income is after expenses and before personal taxes)

UNDERWRITING

8. Has any person proposed for insurance used any tobacco products in the past 12 months?..... Yes No
 9. 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
 10. 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
 11. 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): _____
 12. 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
 13. Is any person proposed for insurance not a United States citizen or legal alien resident of the United States?..... Yes No
 14. Please give the complete details for questions 8 -13 answered "Yes." Include applicable name(s) and item number(s) below:

OTHER INSURANCE

15. Does any person proposed for insurance currently have in-force, applied for or insurance now pending or contemplated for:
- a. Life insurance?..... Yes No
If yes, give complete details _____
 - b. Disability insurance (including individual, group, association, salary continuation and state benefits)..... Yes No
If yes, give complete details _____
16. Will this coverage applied for replace or change any life or disability insurance currently in force? Yes No
If "Yes," please list name of the person proposed for insurance, face amount of insurance, and/or benefit amount; also provide the Company name and submit necessary replacement forms. _____
- _____
- _____

MEDICAL INFORMATION

17. 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. An immune deficiency disorder, AIDS, AIDS Related Complex (ARC), or tested positive for the antibodies to human immunodeficiency virus (HIV)?..... Yes No
 - i. Alcohol or drug use, or used drugs, such as heroin, cocaine, amphetamines, or other narcotics not prescribed by a doctor?..... Yes No
18. Has any person proposed for insurance made a claim for disability or workman's compensation or received such benefits in the past 10 years? Yes No
If "Yes" please list in question 21 the name of the person proposed for insurance, the condition(s) that caused the disability, and the amount and length of time disability benefits were received.
19. 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
20. Has any person proposed for insurance currently taking any prescription medication(s) or been advised to take any medication(s)?..... Yes No
21. Please give complete details to any "Yes" answers for question 17a-i and questions 18 - 20. 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 defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

