

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 [] 30 Year Level Term
[] 15 Year Level Term [] 30 Year Decreasing Term
[] 20 Year Level Term
Proposed Insured Optional Riders
[] Accidental Death Benefit Rider
[] Waiver of Premium Rider
[] Return of Premium Rider
[] Disability Income Rider
Monthly Amount \$
Benefit Period 24 Months
Elimination Period 90 Days

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 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

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
- Note: You need not report any testing information secured from an anonymous counseling and testing site or a home test kit or any test for the HTLV-III antibody if the test is not a FDA licensed test.**
- 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, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false, incomplete, or deceptive statement of a material fact may be guilty of insurance fraud.

