CHS PROTECTION PLUS

LUMP SUM CANCER, HEART ATTACK & STROKE COVERAGE WITH REOCCURRENCE BENEFITS

Underwritten by Guarantee Trust Life Insurance Company

ADH3-12
WHY CANCER, HEART ATTACK & STROKE INSURANCE?

If you were diagnosed with cancer or suffered a heart attack or a stroke, the last thing you would want to worry about is your finances. Cancer, Heart Attack and Stroke coverage from Guarantee Trust Life Insurance Company can help you receive the financial peace of mind that allows you to focus on what really matters most — your recovery.

Because out-of-pocket medical expenses are on the rise, GTL’s CHS Protection Plus Plan was designed to pay cash benefits directly to you and pays regardless of any other insurance coverage you may have should you or a covered family member be diagnosed with cancer, suffer a heart attack or have a stroke.

The Cash Benefits From Your Policy Can Be Used To:

- Supplement Lost Income
- Pay for Experimental Treatments and Surgeries
- Take a Recuperative Trip or Vacation
- Cover Medical Co-Payments and Deductibles
- Allow for Extra Time Off of Work
- Provide Cash for Car and Mortgage Payments

Did You Know?

- 61% of the costs associated with cancer are non-medical, indirect costs?

Under this plan, a lump sum amount will be paid directly to you, regardless of any other health care coverage you may have, upon the diagnosis of cancer or if you suffer a heart attack or stroke. Benefit amounts are flexible, and are eligible to restore through GTL’s New Reoccurrence Benefit. Options can range from $10,000 to $75,000, in increments of $5,000 depending on your specific needs.

**Issue Ages:**
0 – 85 years (age at last birthday)

**Coverage:**
Individual, Single Parent, Couple and Family
*(Each Covered Person(s) will be covered by the same Lump Sum Benefit amount.)*

**Benefit Amounts:**
Minimum face amount is $10,000
Maximum face amount is $75,000
*(In increments of $5,000)*

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HOW CHS PROTECTION PLUS WORKS...

Choose the policy that’s right for you:

1. **LUMP SUM CANCER POLICY:**
   You will receive a lump sum benefit amount paid directly to you upon the diagnosis of cancer[^4], as defined in your policy. With GTL’s *New Reoccurrence Benefit* (see the following page for specifics) that’s included with your coverage, benefits restore after you have been in a period of remission for at least one (1) full year from a previously diagnosed cancer and for which benefits have been paid under this policy.

2. **LUMP SUM HEART ATTACK AND STROKE POLICY:**
   You will receive a lump sum benefit amount paid directly to you upon suffering a heart attack[^5] or a stroke[^6], as defined in your policy. The Lump Sum Heart Attack and Stroke policy also includes GTL’s Reoccurrence Benefit and a Coronary Angioplasty or Coronary Artery Bypass Surgery Benefit[^2] which will pay you ten percent of the selected Lump Sum Heart Attack and Stroke benefit amount should a Covered Person have an Coronary Angioplasty or Coronary Artery Bypass Surgery.

   **PLEASE NOTE:** The Reoccurrence Benefit does not apply to the Coronary Angioplasty or Coronary Artery Bypass Surgery. Benefits are payable one time during the life of your policy and do not reduce the Lump Sum Heart Attack and Stroke benefit amount. Also, this benefit is not payable if the Coronary Angioplasty or Coronary Artery Bypass Surgery is performed as a direct result of a heart attack which immediately preceded the procedure or surgery.

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**Reoccurrence Benefit Applies to:**
- Lump Sum Cancer
- Lump Sum Heart Attack & Stroke Policy
- Heart Attack & Stroke Lump Sum Rider

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**Policy Definitions for the following:**

**Cancer[^4]** means: a malignant tumor which meets the diagnosis criteria of malignancy established by the American Board of Pathology after a study of the histocytologic architecture or pattern of the suspect tumor, tissue or specimen. It is characterized by the uncontrolled growth and spread of malignant cells and the invasion of body tissue by such malignant cells. Cancer includes leukemia and Cancer In Situ. Excluded are Cancers such as: 1) Pre-malignant tumors or polyps; 2) Skin cancer, except malignant melanoma

**Heart Attack[^5]** means: an acute myocardial infarction (irreversible injury and death of a portion of the myocardium or heart muscle) detected by the rise and/or fall of cardiac biomarkers (preferably troponin) with at least one value above the 99th percentile of the upper reference limit (URL) together with evidence of myocardial ischaemia with at least one of the following: Symptoms of ischaemia; ECG changes indicative of new ischaemia (new ST-T changes or new left bundle branch block (LBBB)); Development of pathological Q waves in the ECG; Imaging evidence of new loss of viable myocardium or new regional wall motion abnormality. Heart Attack does not include any other disease or injury involving the cardiovascular system. Cardiac arrest not caused by a myocardial infarction is not a heart attack.

**Stroke[^6]** means: an acute cerebrovascular accident or incident, which results in paralysis or other measurable objective neurological deficit lasting more than 24 hours. A cerebrovascular accident is a sudden, unexpected interference in the brain function caused by insufficient blood flow to part of the brain. Stroke does not mean a head injury, transient ischemic attack or chronic cerebrovascular insufficiency.
The Reoccurrence Benefit is a percentage* of the Lump Sum Benefit paid when cancer reoccurs after you have been in a period of remission for at least one (1) full year from a previously diagnosed cancer and for which benefits have been paid under this policy. (See chart below for details).

For the Lump Sum Heart Attack and Stroke Plan or Rider, reoccurrence must be at least one (1) full year from the date the Lump Sum Benefit was paid (The Reoccurrence Benefit percentages are shown in the chart below).

DID YOU KNOW?

Every year, about 795,000 people in the United States have a stroke. About 610,000 of these are first or new strokes. About 30% of people who survive a stroke go on to have another.7

About two-thirds of people with cancer are expected to live at least five years after diagnosis.8

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Choose Your Optional Supplemental Riders:

1. **LUMP SUM HEART ATTACK AND STROKE RIDER***:
   Should you choose the Lump Sum Heart Attack and Stroke Rider with your Lump Sum Cancer Policy, you will receive a lump sum amount paid directly to you upon the diagnosis of a heart attack or stroke. This benefit is payable only once for each covered person and pays in addition to any other insurance coverage you may have. Benefits are available from $10,000 to $75,000, in increments of $5,000. Should you not be eligible for the Cancer Policy, you can purchase the Lump Sum Heart Attack and Stroke coverage as a stand-alone policy.

   *Reoccurrence Benefit also included.

   The Rider (or stand-alone policy) also includes a Coronary Angioplasty or Coronary Artery Bypass Surgery**, which pays ten percent of the Lump Sum Heart Attack and Stroke Benefit, should you have an Angioplasty or Bypass as defined in your policy. This benefit is not payable if the Coronary Angioplasty or Coronary Artery Bypass Surgery is performed as a direct result of a heart attack which immediately preceded the procedure or surgery.

2. **INTENSIVE CARE RIDER***:
   The Intensive Care Rider pays an indemnity benefit of $150 per unit per day for confinement in an Intensive Care Unit for any reason. The rider pays one half (1/2) the benefit amount for confinement in a step-down unit. Benefits are doubled if confinement occurs within 48 hours of an accident, in which you are the operator or passenger of an automobile, motor home, bus, motorcycle, or any truck with a load capacity of 2,000 or less or as a fare paying passenger on any vehicle, boat, ship, aircraft or train. Benefits are limited to 30 days of confinement in connection with any one hospital admission. Benefits for this rider reduce by 50 percent at age 70.

   **Please note: The Reoccurrence Benefit does not apply to the Coronary Angioplasty or Coronary Artery Bypass Surgery. Coronary Angioplasty and Coronary Artery Bypass Surgery are payable one time during the life of your policy and do not reduce the Lump Sum Heart Attack and Stroke Benefit amount.

   ***Subject to a 30 day waiting period. (Waiting period does not apply in MO. In OK waiting period not applicable to accident).

3. **RETURN OF PREMIUM RIDER**:
   We will return all premiums (less any claims paid) if you pass away prior to age 85.

   Additional Riders Continued on next page ▶️
ThERAPy & WELLNESS RiDER: GTL’s Therapy and Wellness Rider pays an indemnity benefit of $50 per calendar year for one (1) of the following tests:

- MAMMOGRAM
- BREAST ULTRASOUND
- BREAST MRI (MAGNETIC RESONANCE IMAGING)
- CA15-3 (BLOOD TEST FOR BREAST CANCER TUMOR)
- PAP SMEAR
- THIN PREP
- BIOPSY
- FLEXIBLE SIGMOIDOSCOPY
- HEMOCULT STOOL SPECIMEN (LAB CONFIRMED)
- CHEST X-RAY
- MRI
- ANGIOMAP
- ELECTROCARDIOGRAM
- HEART CATHETERIZATION
- CEA (BLOOD TEST FOR COLON CANCER)
- CA 125 (BLOOD TEST FOR OVARIAN CANCER)
- PSA (BLOOD TEST FOR PROSTATE CANCER)
- TESTICULAR ULTRASOUND
- THERMOGRAPHY
- COLONOSCOPY
- VIRTUAL COLONOSCOPY
- SERUM PROTEIN ELECTROPHORESIS
- ECHOCARDIOGRAM
- BLOOD TEST TO CONFIRM ELEVATED CARDIAC ENZYMES
- NEUROIMAGING STUDIES
- THALLIUM SCAN
- CAT SCAN

The Therapy and Wellness Rider also includes the following benefits:

EDUCATIONAL SERVICES BENEFIT: Pays an indemnity benefit of $50 per session for a self-management education and counseling program provided to educate you and your primary caregiver, when needed, to care for your needs as the result of Covered Condition(s) for which you have received other benefits under this policy. This benefit is limited to 12 sessions per calendar year.

HEARING, OCCUPATIONAL, PHYSICAL & SPEECH THERAPY BENEFIT: Pays an indemnity benefit of $25 for each day hearing, occupational, physical and/or speech therapy is needed as a result of a Covered Condition(s) for which you have received other benefits under this policy.

MENTAL HEALTH BENEFIT: Pays an indemnity benefit of $50 per session for counseling for mental and nervous disorders or emotional disease or disorder needed as the result of a Covered Condition(s) for which you have received other benefits under this policy. This benefit is limited to 5 sessions per calendar year.

HEALTHY LIFESTYLE BENEFIT: Pays an indemnity benefit of $25 per calendar year for making healthy lifestyle choices. This benefit is payable if you participate in a smoking cessation program or join a weight loss or physical fitness program. This benefit is payable once per calendar year per covered person that is over the age of 17.

ALTERNATIVE CARE BENEFIT: Integrative Assessment and Education Benefit: A one time benefit of $75 is payable for assessment and/or education services performed by an Accredited Practitioner.

Ameliorative Benefit*: We will pay an indemnity benefit of $25 per visit to an Accredited Practitioner, for up to 20 visits per calendar year for acupuncture, massage therapy, biofeedback and hypnosis.

Lifestyle Benefit*: We will pay an indemnity benefit of $25 per visit for up to 20 visits per calendar year to an Accredited Practitioner for the following types of alternative care: smoking cessation, yoga, meditation, relaxation techniques, Tai-Chi and nutritional counseling.

*Benefit payment subject to a Covered Person providing proof for Injury or Sickness.
PRE-EXISTING CONDITION: A pre-existing condition is a condition for which: (a) Medical advice or treatment was recommended by, or received from a Doctor, within the 24 month period before the Effective Date of the Covered Person’s coverage; or (b) symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 24 month period before the Effective Date of the Covered Person’s coverage.

A pre-existing condition is not covered unless the loss begins more than 24 months after the Effective Date of the Covered Person’s Coverage*.

(*NM, 6 month pre-existing condition limitation; MT, SD 12 month pre-existing limitation; For complete details of all provisions, Please read your policy carefully.)

THE FOLLOWING EXCLUSIONS APPLY TO THE CANCER POLICY AND THE HEART ATTACK AND STROKE POLICY AND RIDER:

EXCLUSIONS: This policy does not cover any loss caused by the following:

THIS PLAN WILL NOT PAY A BENEFIT FOR:

1. Any Cancer diagnosed before the Effective Date of your coverage under the Policy.
2. Any loss due to injury, disease or incapacity, unless related to or attributable to Cancer as defined.
3. Heart Attack or Stroke if first Diagnosed before the Effective Date of your coverage under this Rider or Policy if choosing the Heart Attack and Stroke Policy.
4. Coronary Angioplasty or Coronary Artery Bypass Surgery where medical advice to undergo such procedure or surgery was received before this Rider’s Effective Date.
5. Any loss due to injury, disease or incapacity, unless related to or attributable to Heart Attack or Stroke as defined.

THE FOLLOWING EXCLUSIONS APPLY TO THE INTENSIVE CARE BENEFIT RIDER AND THE THERAPY AND WELLNESS BENEFIT RIDER*: This policy does not cover any loss caused by the following:

*THESE RIDERS DO NOT PROVIDE BENEFITS FOR:

1. Intentionally self-inflicted injury, violating or attempting to violate any duly enacted law.
2. Injury by acts of war, whether declared or not.
3. Attempted suicide while sane or insane.
4. Injury sustained while committing or attempting to commit a felony.
5. Injury sustained while voluntarily participating in a riot, or civil commotion or disturbance of any kind.
6. Loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the injury occurs.
7. Loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a Doctor.

PRE-EXISTING CONDITION: A pre-existing condition is a condition for which: (a) Medical advice or treatment was recommended by, or received from a Doctor, within the 24 month period before the Effective Date of the Covered Person’s coverage; or (b) symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the 24 month period before the Effective Date of the Covered Person’s coverage.

A pre-existing condition is not covered unless the loss begins more than 24 months after the Effective Date of the Covered Person’s Coverage*.

(*NM, 6 month pre-existing condition limitation; MT, SD 12 month pre-existing limitation; For complete details of all provisions, Please read your policy carefully.)

Insurance Underwritten by Guarantee Trust Life Insurance Company: Policy Series G1130/G1131 with rider series, RG11LSHAS, RG10CTW, RG10IC, RG10ROP15, RG10ROP20, RG10ROP25, RG10ROPD

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Ave. Glenview, IL 60025 www.gtlc.com (800) 338-7452. With more than seventy-five years of experience in the insurance industry, Guarantee Trust Life Insurance Company has a proud heritage of providing excellent service and superior insurance products. Guarantee Trust Life Insurance is a mutual legal reserve company located in Glenview, IL, licensed to conduct business in 49 states and the District of Columbia.
### CHS PROTECTION PLUS

Lump Sum Cancer, Heart Attack and Stroke Coverage with Reoccurrence Benefits

#### Annual Rates

Rates do not include a $20 Annual Policy Fee

#### Lump Sum Rate Sheet

For: AL, AK, AR, DE, DC, HI, IL, LA, MI, MO, MT, NE, NM, OK, TN, WI

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### Return of Premium Rider

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We will return premiums (less any claims paid) if you pass away prior to age 85.

Note: ROP not available for ages 80+.

* Rates applied based on original issue age of policy  
** Rider factor applied to total policy premium including any other riders

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### Modal Factors

- MONTHLY PAC: .09
- QUARTERLY: .265
- SEMI-ANNUAL: .52

RATES DO NOT INCLUDE $20 ANNUAL POLICY FEE. (NO ANNUAL POLICY FEE IN THE FOLLOWING STATES: DC, MI)

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### Annual Rates Per $5,000 Benefit

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RATES PER UNIT, MAXIMUM OF 4 UNITS

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[50]
### PREMIUM CALCULATION WORKSHEET

**STEP 1. Determine The Annual Premium**

Divide [Lump Sum Benefit] by 5,000 = [Number of Units] Number of Units

Multiply [Annual Rate] by [Number of Units] = [Annual Premium] Annual Premium

**STEP 2. Determine The Intensive Care Rider Premium** (Optional)

Multiply the [Number of Units] by [Rider Rate] = [Intensive Care Rider Premium] Intensive Care Rider Premium

**STEP 3: Determine The Return of Premium** (Optional)

Add the [Total Annual Premium] = (A) Premium, Multiply by 1.25 (ROP Factor) = [B] Premium

*To Calculate ROP Premium Take (B) Premium Minus (A) Premium.

**STEP 4.** Enter Annual Premium (See STEP 1) $

**STEP 5.** (Optional) Intensive Care Rider (See STEP 2) $

**STEP 6.** (Optional) Therapy & Wellness Rider $

**STEP 7.** (Optional) Return of Premium (See STEP 3) $

**STEP 8.** Add $20 Annual Policy Fee (If Applicable)* $

**STEP 9.** Total Annual Premium (Add STEP 4 Through STEP 8) $

**STEP 10.** Enter Modal Factor (MONTHLY PAC= .09) (QUARTERLY= .265) (SEMI-ANNUAL= .52)

**STEP 11.** Modal Premium $

*No Annual Policy Fee in the Following States: DC, MI

### SAMPLE PREMIUM CALCULATION

This is based on a 40-year old individual who has selected a $15,000 Cancer benefit with the Heart Attack and Stroke Rider, Intensive Care Rider and Return of Premium Rider.

1. Determine the correct rate per $5,000, based on the proposed insured’s age — in this example it is $97.00

2. Take the Lump Sum Benefit and divide it by $5,000 to figure out the number of units of coverage. For example, $15,000/$5,000 = 3 units

3. Multiply the units by the correct rate.
   For example, 3 x $97.00 = $291.00

4. To figure the premium for the Intensive Care Rider, multiply Rider Rate by number of units. In this case: $11.50 x 4 = $46.00

5. To figure the Return of Premium Rider Premium, multiply the Policy Premium and Rider Premium(s) by the Return of Premium Factor - in this case, $291.00 + $46.00 = $337.00 x 1.25 = $421.25. To calculate the ROP Premium ($421.25 - $337.00 = $84.25).

6. Add the Annual Premium, any Rider Premium(s), and the ROP Premium to get the Total Annual Premium. For example, $291.00 + $46.00 + $84.25 = $421.25

7. If paying by monthly PAC take the Total Annual Premium and multiply by the Modal Factor - in this case, $421.25 x .09 = $37.91

Modal Factors: MONTHLY PAC= .09, QUARTERLY= .265, SEMI-ANNUAL= .52
**Application for Cancer Insurance to: Guarantee Trust Life Insurance Company**

1275 Milwaukee Avenue Glenview, IL 60025 (800) 338-7452

**AGENT NOTE:** Please pre-qualify the Applicant(s) with Section C prior to completing the application.

Application for:  □ New Coverage  □ Reinstatement  □ Increase of Benefits
If Reinstatement or Increase requested, please list GTL policy/certificate number(s) affected: __________________________

---

### A. APPLICANT(S) INFORMATION

<table>
<thead>
<tr>
<th>APPLICANT:</th>
<th>MAIL POLICY TO: □ AGENT □ INSURED</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Last Name __________________________</td>
<td></td>
</tr>
<tr>
<td>2. First ____________________________</td>
<td></td>
</tr>
<tr>
<td>3. M.I. _____________________________</td>
<td></td>
</tr>
<tr>
<td>4. Social Security #_________________</td>
<td></td>
</tr>
<tr>
<td>5. □ Male  □ Female  6. Age ______  7. Date of Birth___________</td>
<td></td>
</tr>
</tbody>
</table>

| SPOUSE: | |
| 8. Last Name __________________________ | |
| 9. First ____________________________  | |
| 10. M.I. _____________________________ | |
| 11. Social Security #_________________ | |
| 12. □ Male  □ Female  13. Age ______  14. Date of Birth___________ | |

### DEPENDENTS:

| D1. Last Name __________________________ | First ____________________________ | M.I. ___________________________ |
| □ Male  □ Female  Age _____ Date of Birth________________ | |
| D2. Last Name __________________________ | First ____________________________ | M.I. ___________________________ |
| □ Male  □ Female  Age _____ Date of Birth________________ | |
| D3. Last Name __________________________ | First ____________________________ | M.I. ___________________________ |
| □ Male  □ Female  Age _____ Date of Birth________________ | |

### CONTACT:

15. Street Address ________________________________
20. Telephone __________________________ 21. Email Address __________________________

### BENEFICIARY:

Primary Beneficiary __________________________ Relationship __________________________
Contingent Beneficiary __________________________ Relationship __________________________

---

### B. COVERAGE SELECTION & PREMIUMS

1. **Plan Type:**  □ Individual  □ Single Parent  □ Couple  □ Family

2. **Stand Alone Cancer Policy:**  □ *Lump Sum Benefit Selected:

   *Min: $10,000 Increments of $5,000. Maximum not to exceed $75,000.

3. **Heart Attack and Stroke Rider:**  □ *Lump Sum Benefit Selected:

   *Min: $10,000 Increments of $5,000. Maximum not to exceed $75,000.

4. **Stand Alone Heart Attack and Stroke Policy:**  □ *Lump Sum Benefit Selected:

   *Min: $10,000 Increments of $5,000. Maximum not to exceed $75,000.

5. **Therapy and Wellness Rider:**  □

6. **Intensive Care Rider:** (Pays $150 Per Unit Per Day)

   □ 1 Unit  □ 2 Units  □ 3 Units  □ 4 Units

7. **Return of Premium Rider (upon death):**  □

8. **Premium Payment Mode:**

   **Effective Date:** Draft Date:

   □ Monthly Bank Draft  □ Credit Card

   □ Annual  □ Semi-Annual  □ Quarterly

9. **Premium:**

   (Premium calculated includes a $20 annual policy fee)

   TOTAL: $ __________________________
C. PRE QUALIFICATION, MEDICAL INFORMATION & EXCLUSIONS

1. In the past 5 years has any person to be insured had, been diagnosed as having, received medication for or been treated by a medical practitioner for:
   a) Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS related condition (ARC)?
   b) Leukemia, Hodgkin’s disease, malignant melanoma, sarcoma or any internal cancer, or had radiation or chemotherapy for any of these conditions?
   c) Heart attack, heart bypass, angioplasty, angina, stroke or Transient Ischemic Attack (TIA)?

2. For any of the above conditions which benefits are being applied for, within the past 24 months, has any person to be insured been advised to seek treatment or medical advice from a medical practitioner but not have done so or experienced any symptoms that would have caused a person to seek medical advice from a medical practitioner?

<table>
<thead>
<tr>
<th>Applicant's Answers</th>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.a.</td>
<td></td>
<td></td>
<td></td>
<td>If “YES,” do not submit the application.</td>
</tr>
<tr>
<td>1.b.</td>
<td></td>
<td></td>
<td></td>
<td>If “YES,” the Applicant does not qualify for Cancer Plan benefits. Apply for the Heart Attack/Stroke Plan.</td>
</tr>
<tr>
<td>1.c.</td>
<td></td>
<td></td>
<td></td>
<td>If “YES,” the Applicant does not qualify for Heart Attack/Stroke Plan or benefits.</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td>If “YES,” do not submit the application.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Spouse's Answer</th>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.a.</td>
<td></td>
<td></td>
<td></td>
<td>If “YES,” the Spouse does not qualify for the Plan.</td>
</tr>
<tr>
<td>1.b.</td>
<td></td>
<td></td>
<td></td>
<td>If “YES,” the Spouse does not qualify for the Cancer benefits.</td>
</tr>
<tr>
<td>1.c.</td>
<td></td>
<td></td>
<td></td>
<td>If “YES,” the Spouse does not qualify for Heart Attack/Stroke Plan or benefits.</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td>If “YES,” the Spouse does not qualify for the Plan.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Dependent's Answer</th>
<th>Question</th>
<th>YES</th>
<th>NO</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.a.</td>
<td></td>
<td></td>
<td></td>
<td>If “YES,” dependent(s)________________________ does (do) not qualify for the Plan.</td>
</tr>
<tr>
<td>1.b.</td>
<td></td>
<td></td>
<td></td>
<td>If “YES,” dependent(s)________________________ does (do) not qualify for Cancer benefits.</td>
</tr>
<tr>
<td>1.c.</td>
<td></td>
<td></td>
<td></td>
<td>If “YES,” dependent(s)________________________ does (do) not qualify for Heart Attack/Stroke Plan or benefits.</td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
<td></td>
<td>If “YES,” dependent(s)________________________ does (do) not qualify for the Plan.</td>
</tr>
</tbody>
</table>

D. COVERAGE INFORMATION

APPLICANT:

1. Will any existing in force hospital, medical, or major medical insurance be replaced or changed if the proposed coverage is issued? (If “YES,” please complete the Replacement Form.)
   YES NO
   If “YES,” with which company? __________________________________________________________________________

AGENT’S STATEMENT

I certify that I have accurately recorded the information supplied by the Applicant. I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it. I have advised the applicant not to withhold any information relative to this application and its questions. I have advised the applicant to review the application for completeness and accuracy and that no coverage is in effect until they are notified in writing by Guarantee Trust Life Insurance Company. To the best of my knowledge and belief, the insurance applied for □ is or □ is not likely to replace or change existing insurance or annuities.

Agent’s Name (Printed)  Email Address  Agent Code
 Agent’s Signature  Date
ALL STATEMENTS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY (OUR) KNOWLEDGE AND BELIEF. I (WE) UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I (WE) UNDERSTAND THAT OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR RESCISSION, VOIDING, OR REFORMATION OF INSURANCE.

I (We) understand that any changes in my (our) health conditions or that of my (our) dependents (if applying for dependent coverage), from the date of this application until insurance becomes effective, may result in the declination of my (our) coverage. No agent or other representative of GTL has required, permitted, or encouraged me (us) to answer any question inaccurately or has waived any conditions of this application. I (We) have received a copy of the Pre-Notice which describes how information is obtained and used by GTL.

AUTHORIZATION: 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, pharmacy benefit managers, pharmacies, pharmacy-related facilities 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. Although federal regulations require that the Company inform Me (Us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. 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.

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.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signed at ___________________________ Date ___________________________ City and State ___________________________

Applicant Signature ___________________________ Spouse Signature (if applicable) ___________________________

RECEIPT

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

APPH2-11
GTL AUTHORIZATION TO HONOR CHECKS, SHARE DRAFTS OR ACCOUNT DEBITS

Name of Depositor as it appears on Banking Institution Records:

Last Name ____________________________________ First __________________ M.I. ______

Account # ___________________________ Routing/Transit # ___________________________

Branch ____________________________________________________________

Name of Banking Institution ________________________________________

Address ________________________________________________________________________________

City __________________ State ______ Zip Code ______________________

As a convenience to me, I authorize you to pay me and charge my account checks, share drafts, electronic fund transfer or debits, or other account debits made upon my account by and payable to the order of the entity designated above or its legal representative for membership, benefits and or insurance premiums. I agree that your treatment of each check, share draft or debit, and your rights with respect to it, will be the same as if it were signed or initiated personally by me. I further agree that if any check, share draft or debit and your rights with respect to it, will be the same as if it were signed or initiated personally by me. I further agree that if any check, share draft or debit is dishonored for any reason you will not be under any liability even though dishonor results in the forfeiture of insurance, benefits, or membership. I further agree that this authorization is to remain in effect until you receive written notice from me of its revocation unless you end it earlier.

Signature of Depositor ___________________________ Date ____________

Additional Signature (if joint account) ___________________________ Date ____________

CREDIT CARD AUTHORIZATION

Last Name (on card) ___________________________ First __________________ M.I. ______

Billing Address Street ____________________________________ City __________________

State _____________ Zip Code _____________ Phone ______________________

Card Type (check one) ☐ Visa ☐ Master Card ☐ Discover

Card Number ___________________________ Exp. Date ______-_____

I authorize Guarantee Trust Life Insurance Company to bill my VISA/ MASTERCARD/ DISCOVER for my insurance plan(s) provided by Guarantee Trust Life Insurance Company.

This authorization is to remain in full force until Guarantee Trust Life Insurance Company has received written notification from me of its termination in such time and in such manner as to afford Guarantee Trust Life Insurance Company reasonable opportunity to act upon it.

Signed ___________________________ Date ____________

ADDITIONAL APPLICANT INFORMATION

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________

_______________________________________________________________________________________