Application for Life Insurance to:

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue, Glenview, Illinois 60025

(Please print using dark ink suitable for photocopying)

Last Name (Applicant) First Name Middle Initial	❑ M ❑ F	Soc. Sec. No.	Date Of Birth	State Of Birth	Age	Height	Weight

Home Address	City	State	Zip	Phone Work ( ) Home ( )

OWNER (If other than Applicant)	Relationship

Plan Applied for:	Face Amount $	Modal Premium ❑ Annual ❑ Semi-Annual ❑ Quarterly ❑ PAC	Amount of Premium Collected: $

Beneficiary Name	Beneficiary Relationship

Will this insurance replace or change any other insurance policies or annuities? ❑Yes ❑ No If "Yes", please provide the complete details of the insurance to be replaced, including amount, company and plan of insurance on separate sheet.

TO BE COMPLETED BY THE PERSON TO BE INSURED: To the best of your knowledge and belief:	YES	NO
1. a. Are you currently employed and have you actively and continuously participated in the duties of your regular occupation on a full-time basis (at least 30 hours per week) for the past 6 months?	❑	❑
b. If retired or currently unemployed, are you physically and mentally capable of being employed on an active, full- time basis?	❑	❑
c. Have you been disabled for 30 days or longer during the previous 12 months and has said disability prevented you from performing your normal daily duties or activities or are you currently receiving disability benefits?	❑	❑
2. a. In the last 5 years, have you been diagnosed by a member of the medical profession as having, or have you been tested positive for or been treated by a member of the medical profession for any of the following: Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), HIV virus, or any other disease or disorder of the immune system?	❑	❑
Note: You need not report any testing information secured from an anonymous counseling and testing site or any test for the HTLV - III antibody if the test is not a FDA licensed blood test.		
b. Within the past 24 months, have you used or are you currently using narcotics, amphetamines or any controlled substance, other than on the advice of a physician?	❑	❑
c. Are you now receiving or within the past 12 months have you received chemo or radiation therapy for cancer or have you been diagnosed as being terminally ill?	❑	❑
d. Do you require any assistance with two or more of the following activities: bathing, dressing, toileting, indoor or outdoor mobility, or eating or do you use oxygen for a medical condition?	❑	❑

IN SOME STATES WE ARE REQUIRED TO ADVISE YOU OF THE FOLLOWING: 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.

AUTHORIZATION: I understand and agree that Guarantee Trust Life Insurance Company, its reinsurers, insurance support organizations, and their authorized representatives may obtain medical and other information 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, 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 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).

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
Soliciting Agent Code No.

Date City State/Zip

Print Agent's Name

I represent that the answers to the above questions are complete, true and correct to the best of my knowledge and belief, and acknowledge receipt of the Notice to Applicant Parts 1 and 2. I understand that if I have selected a Graded Death Benefit Plan, the benefit will be limited for a three year period and will remain level thereafter.

X
Signature of Applicant

X
Signature of Proposed Insured (if other than Applicant)

GUARANTEE TRUST LIFE INSURANCE COMPANY

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 there-on to the Medical Information Bureau (MIB), a not-for-profit membership organization of 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, MIB, upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB will arrange disclosure of any information it may have in your file. Please contact MIB at (866) 692-6901(TTY (866) 346-3642). If you question the accuracy of the information in MIB's file, you may contact MIB and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address of MIB's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, e-mail address infoline@mib.com. Guarantee Trust Life Insurance Company or its reinsurers may also release information in its file 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

------------ *detach and return below form with application if Monthly Bank Draft is desired* ------------

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 and association dues draw 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 is 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