

Step 2: Choose Optional Benefits

	Applicant 1			Applicant 2		
Ambulance Rider (Maximum issue age is 80)	<input type="checkbox"/> Modal Premium \$ _____			<input type="checkbox"/> Modal Premium \$ _____		
Accident and Sickness Hospitalization Rider*	Option A:	Option B:	Option C:	Option A:	Option B:	Option C:
Daily Benefit Amount during the Initial Benefit Period: (Choose one) (Daily benefit for the remainder of the 31 day Maximum Benefit Period is \$15)	<input type="checkbox"/> \$100	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300	<input type="checkbox"/> \$100	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200	<input type="checkbox"/> \$100 <input type="checkbox"/> \$200 <input type="checkbox"/> \$300
Initial Benefit Period: (Choose one)	<input type="checkbox"/> 3 Days <input type="checkbox"/> 6 Days	<input type="checkbox"/> 3 Days <input type="checkbox"/> 6 Days	<input type="checkbox"/> 3 Days <input type="checkbox"/> 6 Days	<input type="checkbox"/> 3 Days <input type="checkbox"/> 6 Days	<input type="checkbox"/> 3 Days <input type="checkbox"/> 6 Days	<input type="checkbox"/> 3 Days <input type="checkbox"/> 6 Days
*(HIP option must follow base option.)	Modal Premium \$ _____			Modal Premium \$ _____		
Critical Accident Rider	<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 Modal Premium \$ _____			<input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 Modal Premium \$ _____		
Dental and Vision Rider	<input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 Modal Premium \$ _____			<input type="checkbox"/> \$400 <input type="checkbox"/> \$800 <input type="checkbox"/> \$1,200 Modal Premium \$ _____		

Requested Effective Date: ____/____/____	Premiums	Applicant 1 Total Premium: \$ _____
Requested Effective Date cannot be prior to the Application Date. If no Effective Date is requested, the policy will be effective on the date approved by underwriting.		Applicant 2 Total Premium: \$ _____
		Premiums include an annual \$20 Policy Fee

Step 3: Pre-Qualification and Medical Information

If any answer to questions 1-2 is YES (or 1-3 if applying for Option C), do not submit the application.

	Applicant 1	Applicant 2
1. Is the applicant currently in a nursing home/assisted living facility or receiving home health care or similar type of benefits?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
2. Is the applicant unable to perform routine Activities of Daily Living (bathing, dressing, eating, continence, toileting or transferring to or from a bed or chair without physical assistance) or cognitively impaired?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If applying for Option C:		
3. In the next 60 days, does the applicant expect to be admitted to a hospital, nursing home/assisted living facility or require home health care services or have surgery?	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
Applicant(s) Coverage Information	Applicant 1	Applicant 2
Will any existing supplemental health insurance (including long term care, nursing home, or home health care insurance) be replaced or changed if the proposed coverage is issued? (If "YES," please complete the Replacement Form if required by your state).	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
If "Yes", for which Company?		
Applicant 1 _____		
Applicant 2 _____		

ACKNOWLEDGEMENTS & AUTHORIZATION

APPLICANT ACKNOWLEDGEMENTS

THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

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 FRAUDULENT AND MATERIAL OMISSIONS, INTENTIONAL 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, 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. I (We) have received an Outline of Coverage. If this application is completed electronically, I (we) understand the Outline of Coverage will be delivered electronically or with the policy.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

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 criminal or motor vehicle records needed to underwrite my (our) application for insurance. 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, the Veterans Administration, insurance company, pharmacy benefit manager, pharmacies or pharmacy-related facility which have such information including any medical information provided to any affiliate insurance company on previous applications and medical information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from MIB, Inc. I (We) authorize the Company, or its reinsurers, to make a brief report of my (our) personal health information to MIB, Inc. 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 this authorization will be valid for 24 months from the date signed. I (We) or my (our) authorized representative may have a photocopy of it. In the event my (our) application is approved and coverage is issued, I (We) acknowledge this authorization may also be used to obtain information or records, as stated above, as necessary to process a claim that is submitted within the timeframe during which this authorization remains valid.

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.

This application may be completed by electronic means. I (We) acknowledge that the Company or its agent has verified my (our) identity for this purpose in accordance with any applicable law or regulation and that if completed by electronic means, I (We) have provided my (our) consent and authorization to complete an electronic transaction to apply for coverage. This authorization shall constitute an electronic signature, which is legally binding, and has the same effect as if I (we) had physically signed this application.

I (We) agree that I (we) may receive my (our) policy and other GTL correspondence in electronic format. I (We) acknowledge receipt of the Electronic Delivery and Communications Disclosure, which describes the requirements for Electronic Policy Fulfillment and Communications, as well as my (our) right to opt-out of Electronic Policy Fulfillment and receive a paper copy of my (our) policy (policies), free of charge.

Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

Applicant 1 Signature: _____

Signed at: City and State: _____ Date: _____

Applicant 2 Signature: (if applicable) _____

Signed at: City and State: _____ Date: _____

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.

Agent's Name (Printed)	E-mail Address	Agent Code
Agent's Signature	Date	

APPH5-16-TX

MONTHLY PRE-AUTHORIZED PREMIUM PAYMENT PLAN

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

To _____
Name of my Bank

_____ City State Zip
My Bank's Address

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 Number _____ Banking Routing Number _____

Account Type: Checking Account (*Attach a Voided "Sample" Check*)
 Savings Account (*Attach a Voided "Sample" Check if applicable or a Deposit Slip*)

Requested Draft Date ____/____/____

I agree that my rights in respect to each payment shall be the same as 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 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

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 concerning 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 discussed 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 MIB, Inc.

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 MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, MIB, Inc., will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in MIB, Inc.’s file, you may contact MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address to the MIB, Inc. information office is 50 Braintree Hill Park, Suite 400, Braintree Massachusetts 02184-8734, telephone number (866) 692-6901, e-mail address infoline@mib.com. 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 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

GUARANTEE TRUST LIFE INSURANCE COMPANY

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you the different ways in which Guarantee Trust Life Insurance Company (“GTL”) may use and disclose your protected health information.

Among other things, the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”) requires us to:

- Maintain the privacy of your protected health information.
- Provide notice of GTL’s legal duties and privacy practices with respect to your protected health information.
- Comply with the terms of the Notice currently in effect; and
- Provide you with this Notice.

You have a right to a paper copy of this Notice which will be provided to you upon request, even if this Notice was provided to you electronically.

Protected health information is information about you that is either held or transmitted by GTL, including demographic information, that identifies you (or can reasonably be used to identify you), and that relates to (i) your past, present or future physical or mental health or condition, (ii) the provision of health care to you, or (iii) the past, present or future payment for the provision of health care to you.

GTL understands that your protected health information is personal. We protect the privacy of that information in accordance with all federal and state privacy laws. If a use or disclosure of protected health information described within this Notice, which is required by federal law, is prohibited or materially restricted by state law, GTL will abide by the more stringent law.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITH YOUR WRITTEN AUTHORIZATION

GTL will not use or disclose your protected health information without your written authorization unless the use or disclosure is described within this Notice.

If you have given us written authorization to use or disclose your protected health information, you have the right to revoke that authorization, at any time, except to the extent that: (1) we have already acted in reliance on the authorization; or (2) if the authorization was obtained as a condition of obtaining insurance coverage, other law provides us with the right to contest a claim under the policy or the policy itself. Your written request to revoke an authorization should be directed to the address listed in the “Contact Information” section below.

USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION WITHOUT YOUR WRITTEN AUTHORIZATION

For Payment

We may request, use and disclose your protected health information, as needed, to determine or fulfill our responsibility for coverage and reimbursement for the provision of benefits under your health plan. This may include, but is not limited to:

- determinations of eligibility of coverage (including coordination of benefits with other insurers or the determination of cost sharing amounts) and adjudication or subrogation of health benefit claims;
- risk adjusting based on enrollee health status and demographic characteristics;
- billing, claims management, collection activities, obtaining payment under a contract for reinsurance;
- review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care or justification of charges;
- utilization review activities, including pre-certification and pre-authorization of services, concurrent and retrospective review of services;

- disclosure to consumer reporting agencies of any of the following protected health information relating to collection of premiums or reimbursement: name and address; date of birth; social security number; payment history; policy/account number; and name and address of the health care provider and /or health plan.

For example, if your coverage has a coordination of benefits or other type of cost sharing provision, we may request and disclose protected health information about you to the other health plan carrier to determine the benefits due under the terms of your health plan with us. We may also contact your provider regarding your medical treatments and request details to determine if your coverage will pay for the treatments.

For Health Care Operations

We may use and disclose protected health information about you to support our business operations or the business operations of another insurer. These uses and disclosures are necessary to run the company and make sure all of our policyholders receive the services and benefits provided by their health plan coverage. These activities include, but are not limited to:

- underwriting, premium rating, and other activities relating to the creation, renewal or replacement of a contract of health insurance or health benefits, however, we are prohibited from using or disclosing genetic information about you for underwriting purposes;
- ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
- conducting or arranging for medical review, legal services, and auditing functions, including fraud investigations;
- business planning and development, such as conducting cost-management studies and analyses related to managing and operating the company, including development or improvement of methods of payment or coverage policies; and
- business management and general administrative activities of the company, including, but not limited to:
 - customer service, including the provision of data analyses for policyholders, plan sponsors, or other customers;
 - resolution of internal grievances; and
 - the offer of an enhancement or upgrade to your existing coverage.

To Individuals Involved in Your Care

We may use and disclose your protected health information with your family, friends, personal representative or other individual you identify who are involved in your care or payment of a claim, unless you object. In addition, GTL may use and disclose your protected health information to persons requesting such information if we can reasonably infer from the circumstances that you would not object to the disclosure. If you are not available to give your consent to a disclosure, or in an emergency, we may disclose your protected health information that is directly relevant to such person's involvement in your care or payment for such care.

To Our Business Associates

We may also share your protected health information to an affiliate or business associate outside of GTL if they need protected health information in order to provide services to us (e.g., billing, claim adjudication and underwriting services.) Whenever an arrangement between GTL and a business associate involves the use or disclosure of your protected health information we will have a written contract that sets forth the terms regarding the use and disclosure of your protected health information and will require them to follow the HIPAA rules relating to the protection of protected health information.

For Other Uses and Disclosures

In addition to the above, we are permitted or required by law to use or disclose your protected health information, without your permission, for the following:

- **Lawsuits and Disputes:** If you are involved in a lawsuit or a dispute, we may disclose protected health information about you in response to a court or administrative order. We may disclose protected health information about you in response to a subpoena, discovery request, or other lawful process by someone else involved in the dispute, but only if efforts have been made to tell you about the request or to obtain an order protecting the information requested.
- **Law Enforcement:** We may release medical information if asked to do so by a law enforcement official in response to a court order, subpoena, warrant, summons, or similar process. We may also disclose your protected health information if we suspect child abuse or neglect; we may also disclose your protected health information if we believe you to be a victim of abuse, neglect, or domestic violence.

- **Health Oversight Activities:** We may disclose protected health information to a health oversight agency for activities authorized by law. These oversight activities include, for example, audits, investigations, inspections, and licensure. These activities are necessary for the government to monitor the health care system, government programs, and compliance with civil rights laws.

YOUR RIGHTS REGARDING PROTECTED HEALTH INFORMATION ABOUT YOU

You have the following rights with respect to the protected health information we maintain about you.

You have the right to inspect and copy your protected health information. This means you may inspect and obtain a copy of protected health information about you that is contained in a designated record set for as long as we maintain the protected health information. To inspect and copy protected health information that may be used to make decisions about you, you must submit your request in writing to us or to the business associate who maintains the medical information. If we would prefer to send you a summary or explanation of your medical information rather than the actual records, we may do so only with your consent and your agreement in advance to the fees imposed, if any. You may request your records be in paper or electronic format. We may charge a fee for the costs of copying, mailing or other supplies associated with mailing or copying your protected health information. We may deny your request in whole or in part to inspect and copy records in certain circumstances. If you are denied access to medical information, we will provide a written notice explaining the basis for the denial. You may also request that the denial be reviewed. Such request for review will either be approved or denied based on the grounds for denial. If the initial denial is reviewable, the person conducting the review will not be the same person who denied your original request. We will comply with the determination of the representative performing the review.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any part of your protected health information for the purposes of payment or health care operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposes as described in this Notice. Your request must state the specific restriction requested and to whom you want the restriction to apply. We are not required to agree to a restriction that you may request and we retain the right to terminate an agreed to restriction. Such termination is only effective with respect to protected health information created or received after GTL has informed the individual of its termination of the restriction. Additionally requesting certain limitations may affect payment of benefits under your health plan. To request restrictions, you must make your request in writing to our Customer Service Department. In your request, you must tell us: (1) what information you want to limit; (2) whether you want to limit our use, disclosure, or both; and (3) to whom you want the limits to apply, for example, disclosures to your spouse.

You have the right to request and receive confidential communications. We will accommodate reasonable requests to send your protected health information to you at a different address, or other method of contact. We will not request an explanation from you as to the basis for the request. For example, you can ask that we only contact you at work or by mail. Requests for confidential communications must be made in writing, signed by you and sent to GTL. Your request must specify how or where you wish to be contacted.

You have the right to request an amendment of your protected health information. You may request an amendment of your health information contained in a designated record set for as long as the information is kept by GTL or any of our business associates. To request an amendment, you must send us your request in writing to the address included in the "Contact Information" section below, giving details of your request and why you are making it. If we deny your request for amendment in whole or in part, you have the right to file a statement of disagreement with us and we may prepare a rebuttal to your statement. We will provide you with a copy of any such rebuttal. In certain cases, we may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that: (1) was not created by us, unless the person or entity that created the information is no longer available to make the amendment; (2) is not part of the designated record set kept by us; (3) is not part of the information which you would be permitted to inspect and copy; or (4) is accurate and complete.

You have the right to receive an accounting of certain disclosures. You have the right to request an accounting of most disclosures of protected health information made by us during the six years prior to the date the accounting is requested, subject to certain exceptions. Your request must be in writing. If you request such an accounting more than once in a 12-month period, we may charge a cost-based reasonable fee.

You have the right to be notified following a breach of unsecured protected health information. You have the right to and will receive a notification of a breach of your unsecured protected health from GTL, or one of its business associates.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint in writing to us at the address shown below in the "Contact Information" section. You may also file a complaint in writing with the Secretary of the Department of Health and Human Services. You will not be retaliated against for filing a complaint.

THIS NOTICE IS SUBJECT TO CHANGE

We reserve the right to change the terms of this Notice and our privacy policies at any time. If we do, the new terms will be effective for all protected health information maintained by us, including protected health information received by GTL before the effective date of the new terms. If we do revise our privacy notice, a copy of the new notice will be posted on our web site at www.gtlic.com and/or sent to you if the changes are material.

EFFECTIVE DATE

This Notice is effective September 23, 2013.

CONTACT INFORMATION

If you have questions regarding this Notice or require further information, you may contact our Customer Service Department at 1-800-338-7452. Any written complaints should be directed to Guarantee Trust Life Insurance Company, Attention: Privacy Office, 1275 Milwaukee Avenue, Glenview, Illinois 60025.

GUARANTEE TRUST LIFE INSURANCE COMPANY

Glenview, Illinois

**NOTICE TO APPLICANT
REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by The Guarantee Trust Life Insurance Company. Your new policy provides 10 days within which you may decide without cost whether you desire to keep the policy. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

- (1.) Health conditions which you may presently have (pre-existing) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2.) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interests to make sure you understand all the relevant factors involved in replacing your present coverage.
- (3.) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/ health history. Failure to include all material medical information on any application may provide basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

The above "Notice to Applicant" was delivered to me on _____
Date

Applicant's Signature