

SERFF Tracking Number: GRTT-125663666 State: Arkansas
 Filing Company: Guarantee Trust Life Insurance State Tracking Number: 39162
 Company Tracking Number:
 TOI: H02I Individual Health - Accident Only Sub-TOI: H02I.000 Health - Accident Only
 Product Name: G0760 Accident Only
 Project Name/Number: Platinum Accident Plan/

Filing at a Glance

Company: Guarantee Trust Life Insurance
 Product Name: G0760 Accident Only
 TOI: H02I Individual Health - Accident Only
 Sub-TOI: H02I.000 Health - Accident Only
 Filing Type: Form/Rate

SERFF Tr Num: GRTT-125663666 State: ArkansasLH
 SERFF Status: Closed State Tr Num: 39162
 Co Tr Num: State Status: Approved-Closed
 Co Status: Reviewer(s): Rosalind Minor
 Author: Theresa Tyc Disposition Date: 07/07/2008
 Date Submitted: 06/01/2008 Disposition Status: Approved-Closed
 Implementation Date: Implementation Date:

Implementation Date Requested: On Approval
 State Filing Description:

General Information

Project Name: Platinum Accident Plan
 Project Number:
 Requested Filing Mode: Review & Approval

Status of Filing in Domicile: Pending
 Date Approved in Domicile:
 Domicile Status Comments: This filing has been concurrently submitted to our state of domicile, Illinois.
 Market Type: Individual
 Group Market Size:
 Group Market Type:
 Deemer Date:

Explanation for Combination/Other:
 Submission Type: New Submission
 Overall Rate Impact:
 Filing Status Changed: 07/07/2008
 State Status Changed: 07/07/2008
 Corresponding Filing Tracking Number:
 Filing Description:

This filing is for an Accident Only policy with Return of Premium benefit riders. These forms are new and will not replace any form currently on file with your Department. The forms are for use on a general basis. Coverage will be solicited on an individual face-to-face basis, as well as via work site marketing.

The actuarial memorandum, filing exhibits and annual premium rates (premium factors for the benefit riders) are

SERFF Tracking Number: GRTT-125663666 *State:* Arkansas
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included in the filing.

Policy form G0760-AR is an Accident Only policy which provides various indemnity benefits, such as hospital confinement, emergency room, ambulance, surgical, and therapy benefits for injuries sustained as a result of an accident. The policy also provides a limited disability income benefit, as well as benefits for accidental death and dismemberment. The policy offers a choice of benefit levels as indicated in the attached Benefit Schedules (Plans A through E.)

The policy provides coverage on an individual basis. The primary insured, his or her spouse and dependent children may apply for coverage under the same policy, at the same or different benefit schedules. Annual premiums charged are on a per person covered basis.

Coverage will include one of the following return of premium benefits: (1) RG07ROP(D) offers a return of premium if the primary insured dies prior to age 80; or (2) RG07ROP(T) returns premiums at the end of a specified term, i.e. 15 or 20 years. Both return of premium options return 100% of premium paid for all covered persons less claims paid on all covered persons. We request general approval of these riders. At the company's option, it will make one of the two above choices the default return of premium benefit to be included with coverage.

Application APPH1-08 will be used in the solicitation of this product on an individual basis. APPH1-08(W) will be used for work site marketing. Sections A and B of this application are filed as variable. It is not our intention to make any changes to the application that would cause it to be out of compliance with any statutory requirements.

The outline of coverage has also been included on an informational basis.

We use multiple computer systems to generate forms. Therefore, actual issued forms may have a different font style than the submitted form. As a result, provisions may appear on different pages and lines may not match up exactly. The wording and its order, however, will remain identical. We do not anticipate refiling for a font style variation.

We respectfully request your favorable consideration and approval of this filing.

SERFF Tracking Number: GRTT-125663666 State: Arkansas
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 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
 Product Name: G0760 Accident Only
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Company and Contact

Filing Contact Information

Theresa Tyc, Director tatyc@gtlic.com
 1275 Milwaukee Ave. (847) 460-4783 [Phone]
 Glenview, IL 60025 (847) 699-0093[FAX]

Filing Company Information

Guarantee Trust Life Insurance CoCode: 64211 State of Domicile: Illinois
 1275 Milwaukee Avenue Group Code: 687 Company Type: Mutual
 1275 Milwaukee Avenue
 Glenview, IL 60025 Group Name: State ID Number:
 (847) 460-4772 ext. [Phone] FEIN Number: 36-1174500

Filing Fees

Fee Required? Yes
 Fee Amount: \$250.00
 Retaliatory? Yes
 Fee Explanation: 5 forms @ \$50 ea. = \$250.00
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Guarantee Trust Life Insurance	\$250.00	06/01/2008	20607741

SERFF Tracking Number: GRTT-125663666 State: Arkansas
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Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	07/07/2008	07/07/2008

Objection Letters and Response Letters

Objection Letters				Response Letters		
Status	Created By	Created On	Date Submitted	Responded By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	06/09/2008	06/09/2008	Theresa Tyc	07/06/2008	07/06/2008

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Disposition

Disposition Date: 07/07/2008

Implementation Date:

Status: Approved-Closed

Comment:

Rate data does NOT apply to filing.

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Item Type	Item Name	Item Status	Public Access
Supporting Document	Certification/Notice	Approved-Closed	Yes
Supporting Document	Application	Approved-Closed	Yes
Supporting Document	Health - Actuarial Justification	Approved-Closed	No
Supporting Document	Outline of Coverage	Approved-Closed	Yes
Supporting Document	Statement of Variability	Approved-Closed	Yes
Supporting Document	Actuarial Exhibits	Approved-Closed	No
Form (revised)	Accident Only Policy	Approved-Closed	Yes
Form	Accident Only Policy	Withdrawn	Yes
Form	Return of Premium Upon Death Benefit Rider	Approved-Closed	Yes
Form	Return of Premium at End of Specified Term Benefit Rider	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application for work site markets	Approved-Closed	Yes
Rate	G0760 Annual Premium Rate Sheet	Approved-Closed	Yes
Rate	RG07ROP(D) Premium Factors	Approved-Closed	Yes
Rate	RG07ROP(T) Premium Factors	Approved-Closed	Yes

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Objection Letter

Objection Letter Status Pending Industry Response
Objection Letter Date 06/09/2008
Submitted Date 06/09/2008

Respond By Date
Dear Theresa Tyc,

This will acknowledge receipt of the captioned filing.

Objection 1

- Accident Only Policy (Form)

Comment: With respect to your definition of Accident, this is to advise that "Accident", "Accidental Injury", or "Accidental Means" may be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which is the direct cause, independent of disease or bodily infirmity or any other cause and occurs while the insurance is in force. Refer to Rule 18, Section 5 D.

Objection 2

- Accident Only Policy (Form)

Comment: With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Please feel free to contact me if you have questions.

Sincerely,
Rosalind Minor

Response Letter

Response Letter Status Submitted to State
Response Letter Date 07/06/2008
Submitted Date 07/06/2008

Dear Rosalind Minor,

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Comments:

Response 1

Comments: This acknowledges receipt of the June 9 objection letter. Our responses to numbered objection are listed below.

Objection 1 - We have removed the word "external" from the definition of "Accident" on page 4 of policy G0760-AR.

Objection 2 - We have amended the "Termination" provision with respect to handicapped dependents in accordance with Arkansas Insurance Code 23-85-131(b).

As always, your further consideration of this filing for approval is sincerely appreciated.

Related Objection 1

Applies To:

- Accident Only Policy (Form)

Comment:

With respect to your definition of Accident, this is to advise that "Accident", "Accidental Injury", or "Accidental Means" may be defined to employ "result" language and shall not include words which establish an accidental means test or use words such as "external, violent, visible wounds" or similar words of description or characterization.

The definition shall not be more restrictive than the following: Injury or injuries, for which benefits are provided, means accidental bodily injury sustained by the insured person which is the direct cause, independent of disease or bodily infirmity or any other cause and occurs while the insurance is in force. Refer to Rule 18, Section 5 D.

Related Objection 2

Applies To:

- Accident Only Policy (Form)

Comment:

With respect to handicapped dependents, there can be no time limit set for furnishing proof of incapacity. Refer to ACA 23-85-131(b) and Bulletin 14-81.

Changed Items:

No Supporting Documents changed.

Form Schedule Item Changes

SERFF Tracking Number: *GRTT-125663666* *State:* *Arkansas*
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TOI: *H02I Individual Health - Accident Only* *Sub-TOI:* *H02I.000 Health - Accident Only*
Product Name: *G0760 Accident Only*
Project Name/Number: *Platinum Accident Plan/*

Form Name	Form Number	Edition Date	Form Type	Action	Action Specific Data	Readability Score	Attach Document
Accident Only Policy	G0760-AR		Policy/Contract/Fraternal Certificate	Initial		42	G0760-AR.pdf
<i>Previous Version</i>							
<i>Accident Only Policy</i>	<i>G0760-AR</i>		<i>Policy/Contract/Fraternal Certificate</i>	<i>Initial</i>		42	G0760-AR.pdf

No Rate/Rule Schedule items changed.

Sincerely,
Theresa Tyc

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Form Schedule

Lead Form Number: G0760

Review Status	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed	G0760-AR	Policy/Cont	Accident Only Policy ract/Fratern al Certificate	Initial		42	G0760-AR.pdf
Approved-Closed	RG07ROP(D)	Policy/Cont	Return of Premium ract/Fratern Upon Death Benefit al Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		45	RG07ROP(D).pdf
Approved-Closed	RG07ROP(T)	Policy/Cont	Return of Premium at ract/Fratern End of Specified al Term Benefit Rider Certificate: Amendmen t, Insert Page, Endorseme nt or Rider	Initial		46	RG07ROP(T).pdf
Approved-Closed	APPH1-08	Application/	Application Enrollment Form	Initial			APPH1-08.pdf
Approved-Closed	APPH1-08(W)	Application/	Application for work Enrollment site markets Form	Initial			APPH1-08(W).pdf

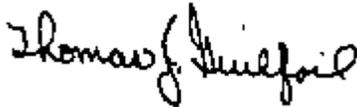
**GUARANTEE TRUST LIFE
INSURANCE COMPANY**
A Mutual Company
1275 Milwaukee Avenue
Glenview, Illinois 60025
(847) 699-0600

**ACCIDENT ONLY
POLICY**

Includes Limited Benefits for
Disability Income

**THIS IS A LEGAL
CONTRACT BETWEEN
YOU AND US. READ YOUR
POLICY CAREFULLY.**

Signed for Guarantee Trust Life
Insurance Company, at its Home
Office, by:



Secretary



President

WE PROMISE to insure You for the benefits described in this Policy. Benefits are subject to the Policy definitions, provisions, limitations and exclusions. This Policy is issued in consideration of the application and payment of the first Premium. The application is attached to and made a part of this Policy.

Licensed Resident
Agent

GUARANTEED RENEWABLE. You may keep this Policy in force during Your entire lifetime by paying the renewal premium at the intervals available to You at the time of renewal. You must pay the premium when due or within the grace period. We cannot cancel or refuse to renew this Policy or place any restrictions on it if You pay Your Premiums on time.

YOUR RIGHT TO EXAMINE THIS POLICY FOR TEN (10) DAYS. It is important to us that you are satisfied with this Policy. If You are not satisfied with this Policy, You may return it to us within ten (10) days of its receipt. Upon Our receipt of Your returned Policy, We will cancel the Policy as of the Effective Date and refund any premiums You have paid.

PREMIUMS ARE SUBJECT TO CHANGE. The premium rates for this policy may change, but only if they are changed for all policies like Yours on a class basis. The change may be due to an increase in age, a change in benefits, or a new table of rates. We will provide You with written notice at least thirty-one (31) days in advance of any change in renewal premium.

IMPORTANT NOTICE

Please read the copy of the application attached to this Policy. Carefully check the application and write to Us at the address shown above within ten (10) days if any information shown on it is not correct and complete. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your policy. The application is a part of this Policy and this Policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

If You have any problems, complaints or questions concerning this Policy, please write Us at the above address or call us at 800 338-7452. If We are unable to satisfy You, You may write the Arkansas Consumer Services Division, Department of Insurance, 1200 W. Third Street, Little Rock, AR 72201-1904 or call 800 282-9124.

**THIS IS AN ACCIDENT ONLY POLICY.
IT DOES NOT PAY BENEFITS FOR LOSS AS A RESULT OF SICKNESS.**

**THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare,
review the Medicare Supplement Buyer's Guide available from the Company.**

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Benefit and Fracture Schedule(s) Attached

CONSIDERATION

We have issued this policy in consideration of the statements made in the application and payment of the First Premium. The application is attached and made a part of this policy.

POLICY DEFINITIONS

Accident: A sudden and unforeseeable event that results in an Injury.

Actively At Work (Active Work): Means a Covered Person is performing the Substantial and Material Duties of his or her Regular Occupation at the normal place of business for thirty (30) or more hours per week.

Ambulance: A vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means. Air ambulance charges are only eligible for transportation from the site of an Emergency to the nearest appropriate facility.

Ambulatory Surgical Center: A facility that is accredited by a national accrediting body or licensed by a state agency and which:

- Is equipped and operated to provide medical care and treatment by a Doctor;
- Does not provide services or accommodations for overnight stays;
- Has a full time medical staff that is under the supervision of a duly licensed Doctor;
- Has at least one licensed registered nurse (R.N.) on duty at all times when patients are in the facility;
- Has at least one operating room and one recovery room and is equipped to support any surgery performed;
- Has X-ray and laboratory diagnostic facilities;
- Maintains a medical record for each patient; and
- Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need confinement.

Calendar Year: The period beginning on the date a Covered Person's coverage becomes effective and ending on December 31 of that same year. Form then on, it is the period beginning January 1 and ending on December 31 of that same year.

Chiropractic Treatment: A Medically Necessary treatment or procedure performed by a Doctor of chiropractic.

Common Carrier: Any scheduled airline, land, or water conveyance licensed for the transportation of passengers for hire. Common Carrier does not include a conveyance operated for sport, recreation, and/or sightseeing activities or for any travel in any aircraft device for aerial navigation except as expressly provided in the policy.

Covered Person: Means You or a person:

1. who is eligible for coverage as Your Dependent
2. who has been accepted for coverage or has been automatically added.
3. who has paid the required premium; and
4. whose coverage has become effective and has not terminated.

Covered Person, for purposes of the Monthly Disability Income Benefit is limited to You and Your Dependent spouse, if also insured under this Policy.

Daily Benefit Amount: The amount We will pay each day when Hospital Confined due to Injury. The Daily Benefit Amount is shown in the Benefits Schedule.

Dental Treatment: A Medically Necessary treatment or procedure performed in the oral cavity.

Policy Definitions (Continued)

Dependent: A person who is Your:

1. legally married spouse (or state recognized common law spouse), residing with You.
2. child who is dependent upon You for support and maintenance and is under the age of nineteen (19).
3. child who is dependent upon You for support and maintenance, is nineteen (19) through twenty-five (25) years of age and is attending school full time, as determined by the school the Dependent is attending, including colleges and vocational, technical, vocational-technical or trade schools or institutes.

The term child refers to Your and Your spouse's unmarried:

1. natural child;
2. stepchild; a stepchild is a Dependent on the date You marry the child's parent; and
3. adopted child, including a child placed with You for the purpose of adoption, from the moment of placement as certified by the agency making the placement.

Disability / Disabled: Means a Covered Person who:

- is unable, due to an Injury, to do the Substantial and Material Duties of his or her Regular Occupation for Wage or Profit as such existed at the start of any Disability for which a claim for benefits is made under this Policy;
- is receiving regular care by a Doctor that is appropriate for the Injury causing the Disability. This care must be at such intervals as will lead to his or her return to work. The Covered Person need not be under a Doctor's care on a regular basis if he or she can show that further recovery is not expected; and
- is not doing any other work for Wage or Profit.

Disability Income Benefit Period: The maximum number of months the Monthly Disability Income Benefit will be paid for a Period of Disability. The Disability Income Benefit Period is shown in the Benefits Schedule.

Doctor: A legally qualified person licensed in the healing arts and practicing within the scope of his or her license. A Doctor does not include You or a Family Member.

Elimination Period: The number of consecutive days after a Disability starts during which the Monthly Disability Income Benefit is not paid. The Elimination Period must be satisfied for each Period of Disability incurred. The Elimination Period is shown in the Benefits Schedule.

Emergency: An Injury for which a Covered Person seeks immediate medical treatment at the nearest available Hospital. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care the Covered Person could reasonably expect that: (1) his or her life or health would be in serious jeopardy; (2) his or her bodily functions would be seriously impaired; or (3) a body organ or part would be seriously damaged.

Experimental/Investigational: A drug, device or medical care or treatment will be considered experimental/investigational if:

- the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug is administered or the device is furnished;
- the informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- the drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- reliable evidence show that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
- reliable evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Charges will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

Policy Definitions (Continued)

Family Member: A person, including You, who is related to a Covered Person in any of the following ways: spouse (includes state recognized common-law), brother-in-law, sister-in-law, son-in-law, daughter-in-law, father-in-law, mother-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child.)

Hospital: An institution licensed, accredited, or certified by the State which:

- is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
- provides 24-hour nursing service by registered nurses (R.N.);
- mainly provides diagnostic and therapeutic care under the supervision of Doctors on an inpatient basis; and
- maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital does not include a place, special ward, floor, or other accommodation used for: custodial, educational care, or rehabilitation; rest; the aged; a nursing home or an institution mainly rendering treatment or services for mental or nervous disorders or substance abuse.

Hospital Confined/Hospital Confinement: Confinement in a Hospital for at least 24 consecutive hours by reason of an Injury for which benefits are payable and there is a charge for room and board.

Injury / Injuries: Bodily injury due to an Accident which:

- results directly and independently of disease, bodily infirmity or any other causes;
- solely, directly and independently of all other causes results in medical expense;
- occurs after the effective date of the Covered Person's coverage under this Policy; and
- occurs while this Policy is in force.

All Injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.

Maximum Disability Income Benefit: The maximum number of Monthly Disability Income Benefit payments payable for all combined Periods of Disability per Covered Person. The Maximum Disability Income Benefit is shown in the Benefit Schedule.

Medically Necessary: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of an Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A treatment, drug, device, procedure, supply, or service shall not be considered as Medically Necessary if it:

- is Experimental/Investigational or for research purposes;
- is provided solely for education purposes or the convenience of the Covered Person, the Covered Person's family, Doctor, Hospital or any other provider;
- exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- could have been omitted without adversely affecting the person's condition or the quality of medical care;
- involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- can be safely provided to the patient on a less cost-effective basis such as outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

We reserve the right to determine whether a service, supply, or drug is Medically Necessary.

Policy Definitions (Continued)

Medical Treatment: Medically Necessary treatment or procedure provided to a Covered Person by a Doctor and which is received solely as a result of an Injury.

Mental or Nervous Disorder: Any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to the Covered Person.

Monthly Disability Income Benefit: The amount payable, after the Elimination Period is satisfied, for each month the Covered Person is Disabled. The Monthly Disability Income Benefit amount is shown in the Benefit Schedule.

Outpatient Facility: A facility which

- Meets licensing and other legal requirements and is equipped to provide surgical services;
- Classified by the Hospital as an out-patient facility; and
- In which you are confined for less than 24 hours.

Period of Disability: A period of disability begins on the date of the first treatment by a Doctor for the Disability. It ends upon a return to Active Work for a period of not less than 90 days.

Prosthesis: An artificial substitute or replacement of an external body part. Covered prosthesis includes, but is not limited to: arm, leg, hip, knee, eye, or ear. It does not include dental prosthetics.

Recurrent Disability: A Disability will be considered a recurrence of a prior Disability if it is due to the same or related causes as the prior Disability and is separated from the prior Disability by less than 90 days of return to Active Work. Such Recurrent Disability will be subject to the Policy's provisions that were in effect at the time the prior Disability began.

Disability that begins more than 90 days after the end of a prior Disability shall be subject to:

- A new Elimination Period;
- Any Maximum Disability Income Benefit remaining; and
- The other provisions of the Policy that are in effect on the date Disability recurs.

Regular Occupation: The occupation(s) that a Covered Person is performing for Wage or Profit on the date he or she becomes Disabled.

Sickness means illness or disease which manifests itself while this Policy is in force. Complications of pregnancy will be considered a sickness.

Sound Natural Teeth: Natural teeth, the major portion of the individual tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

Substantial and Material Duties: The necessary functions of a Covered Person's Regular Occupation which cannot be altered or reasonably omitted.

Wage or Profit: Salaries, bonuses, commissions, fees, and other income amounts received as payment for personal services rendered or work performed and based on an average forty (40) hour workweek. Wage or Profit also includes any contribution made by a Covered Person or on his or her behalf to any pension, profit sharing, or deferred compensation plan, unless such contributions are waived during a Period of Disability. Wage or Profit does not include dividends, rents, royalties, annuities, or other forms of unearned income. Proof of current Wage may be required when filing a claim under Part K of this policy.

We, Us, Our and Company: Guarantee Trust Life Insurance Company.

You, Your and Yours: The person named as the Insured in the Policy Schedule.

ELIGIBILITY AND ADDITIONS

Section A – General Eligibility

A person who makes application for coverage under the Policy will become an Insured person if he or she meets our underwriting standards for coverage.

If You are eligible to apply for coverage under the Policy, You may apply to include as Covered Persons:

1. Your lawful spouse (or state recognized common law spouse);
2. each unmarried child of Yours who is a Dependent.

Section B – Dependents Acquired After Effective Date

Newborn Child: Your newborn child is automatically covered from the moment of birth until such child is thirty-one (31) days old. Coverage for such child will be for Injury. However, You must notify Us in writing within thirty-one (31) days of such birth and pay the required additional premium, if any, in order to have coverage for the newborn child continue beyond such thirty-one (31) day period.

Adopted Child: Coverage for an adopted child shall begin on the date of the filing of a petition for adoption. If You apply for coverage within sixty (60) days after the filing of the petition for adoption. However, coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the minor.

Other Than Newborn or Adopted Child: A person who qualifies as a Dependent after the Effective Date of coverage may be insured under this Policy. Application and premium must be received by Us within thirty-one (31) days after the date the person first qualifies as a Dependent, and the required premium must be paid. Coverage is effective upon receipt of an application for coverage, our underwriting standards are met and premium is paid.

If You do not meet the applicable requirements, a child as set forth in this section will cease to be a Covered Person at the end of the thirty-one (31) day period.

Section C – Termination

A child will cease to be covered on the premium due date that follows the earlier of such child's: (a) nineteenth (19th) birthday, twenty-fifth (25th) birthday if a full-time student; or (b) date of marriage.

The coverage of a child will not terminate if that child is both: (a) incapable of self-sustaining employment because of mental retardation or physical handicap; and (b) currently dependent upon You. At Our request and Our expense, proof of the incapacity or dependency must be furnished to Us by You. You must notify Us if the incapacity or dependency is thereafter removed or terminated.

Coverage of Your spouse shall cease on the premium due date that follows the date of entry of a valid judgment of dissolution of marriage.

Section D – Continuation of Coverage

If You die, Your spouse, if any and covered under this Policy, will become the Insured and have the right to continue coverage for all Covered Persons under this Policy. A written request for continuation of coverage for all Covered Persons and the appropriate premium must be received by Us within thirty-one (31) days after Your death. Upon Our receipt of such written request and premium, We will issue a new policy. The new policy will be issued based on the attained age(s) of the Insured and any remaining dependent children.

We will terminate this Policy if the written request for continuation and the appropriate premium is not received by Us within thirty-one (31) days after Your death.

ELIGIBILITY AND ADDITIONS (Continued)

Section E – Conversion Option:

A covered Dependent may apply for a Conversion policy if coverage under this Policy terminates, except for non-payment of premium, as set forth in the Termination provision. The Conversion Policy will be issued without proof of good health, subject to the following conditions: a written application for the Conversion policy is sent to Us within thirty-one (31) days of the date on which such person's coverage under this Policy ends. The Effective Date of the Conversion policy shall be the date such person's coverage ended under this Policy. The premium for the Conversion policy will be based on: (1) the attained age of the covered Dependent; and (2) the premium rate table currently in effect for the Conversion policy form and amount of coverage provided.

1. The Conversion policy will be this or a similar form currently in use by Us.
2. the Conversion policy may exclude any condition excluded by this Policy with respect to the covered Dependent at the time of the termination of coverage under this Policy. We will not pay benefits under the Conversion policy for expenses incurred while this Policy is in force.
3. any benefit amounts paid for a covered Dependent under this Policy will be applied to any benefit limits under the converted policy.

Termination of coverage because a person ceases to be a Covered Person is without prejudice to any claim originating prior to termination of coverage.

BENEFIT PROVISIONS

Please refer to the Benefits Schedule Page for the benefit amounts payable and limits for each of the benefits listed below. Unless specified otherwise, benefit limits shown below are per Covered Person.

A. DAILY HOSPITAL CONFINEMENT BENEFIT

We will pay the Daily Benefit Amount for ninety (90) days for each day a Covered Person is Hospital Confined when such confinement is Medically Necessary as a result of an Injury.

The Daily Benefit Amount will double if the Hospital Confinement continues on and beyond the ninety-first (91st) day from the initial Hospital Confinement for the same Accident.

The Daily Benefit Amount is payable for up to three-hundred sixty five (365) days of Hospital Confinement per Accident.

B. AMBULANCE SERVICE BENEFIT

We will pay the Ambulance Service Benefit for air or ground Ambulance service when needed to transport a Covered Person to the nearest available Hospital due to an Injury. The Ambulance Service Benefit is limited to:

- (1) One (1) transport per Accident for ground transport service, not to exceed payment for four (4) ground Ambulance transports per Calendar Year;
- (2) One (1) transport per Accident for air transport services per Calendar Year.
- (3) One transport per Accident (either ground or air.) If both modes of transport are used for one Accident, benefits will be payable at the air transport services benefit level.

C. EMERGENCY ROOM BENEFIT

We will pay for services rendered to a Covered Person in a Hospital emergency room or Hospital affiliated emergency care facility for loss sustained as a result of an Injury. Emergency treatment must be sought within twenty-four (24) hours of the Accident. The Emergency Room Benefit is limited to one (1) Emergency Room treatment per Accident, not to exceed four (4) Emergency Room treatments per Calendar Year.

D. EMERGENCY MEDICAL, DENTAL OR CHIROPRACTIC TREATMENT BENEFIT

We will pay for Emergency Medical, Dental, or Chiropractic treatments a Covered Person receives as result of an Injury. Payment is limited to a combined total of six (6) visits per Calendar Year for any and all Medical, Dental, or Chiropractic Treatments received.

BENEFIT PROVISIONS (Continued)

E. OUTPATIENT THERAPY

We will pay the Outpatient Therapy benefit for outpatient therapies a Covered Person receives as a result of an Injury. Covered therapies are limited to physical, speech, hearing and occupational. Payment for this benefit is limited to a combined total of six (6) visits for all forms of therapy per Accident.

F. FIRST OCCURRENCE CONFINEMENT

We will pay the First Occurrence benefit in the event a Covered Person is Hospital Confined within twenty-four (24) hours of sustaining an Injury. The First Occurrence benefit is limited to one (1) payment per Accident, not to exceed two (2) payments under this benefit provision per Calendar Year.

G. PROSTHESIS BENEFIT

We will pay the Prosthesis benefit when a Covered Person receives a prosthesis or prosthetic device as a direct result of an Injury. The Prosthetics benefit is limited to one (1) payment per Accident. This benefit does not cover replacement of any existing prosthesis.

H. FRACTURE BENEFIT

We will pay the Fracture benefit, as shown in the Fractures Schedule, when a Covered Person receives services that are deemed to be Medically Necessary for the treatment of a fracture sustained as a direct result of an Injury. A fracture for the purposes of coverage under this policy refers to a break in bone or cartilage which is the result of trauma. It does not include a fracture caused by an acquired disease, such as osteoporosis or Padgett's disease or by abnormal formation of bone in a disease such as osteogenesis imperfecta. The Fracture benefit is limited to one (1) payment per Accident, not to exceed four (4) payments under this benefit provision per Calendar Year.

I. OUTPATIENT SURGICAL BENEFIT

We will pay the Outpatient Surgical Benefit for a surgical procedure performed by a Doctor when such procedure is performed in a Hospital, Ambulatory Surgical Center or Outpatient Facility of a Hospital. The surgery must be deemed Medically Necessary and performed as a result of a sustained Injury. The Surgery benefit is limited to one (1) payment per Accident without regard to the number of surgical procedures rendered.

J. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

We will pay the Accidental Death Benefit to the beneficiary named in the application (or as later changed) if a Covered Person should die solely as a result of Injuries. Accidental death must occur while this Policy is in force for the Covered Person and within ninety (90) days after the Accident causing the Injuries.

We will pay the appropriate Accidental Dismemberment Benefit if a Covered Person suffers total and irrecoverable loss of eyesight or limbs solely as the result of an Injury. The dismemberment must occur while this Policy is in force for the Covered Person and within ninety (90) days after the Accident causing the Injuries.

Loss means with regard to hands and feet, dismemberment by severance through or above the wrist or ankle joint; with regard to eyes, the loss of sight must be total and irrecoverable, and beyond remedy by surgical or other means.

For all loss (dismemberment and/or death) sustained as a result of one Accident, We will pay the greater of the benefit amount for loss due to dismemberment or for loss due to death or balance thereof if dismemberment benefits have been previously paid.

K. DISABILITY INCOME BENEFIT

This benefit is limited to You and Your Dependent spouse, if insured under this Policy.

We will pay the Monthly Disability Income Benefit for Disability due to an Injury. Benefit payment is subject to the satisfaction of the Elimination Period. Disability must start within thirty (30) days after the Accident causing the Injury. The Injury must occur while coverage under the policy is in force for the Covered Person.

The Disability Income Benefit is limited to:

- (1) The Monthly Disability Income Benefit amount;
- (2) The Disability Income Benefit Period per Period of Disability, inclusive of Recurrent Disability; and
- (3) The Maximum Disability Income Benefit for all combined Periods of Disability.

BENEFIT PROVISIONS (Continued)

Disability Income Benefit: (Continued)

After the Maximum Disability Income Benefit payments have been made for a Covered Person, any future payment of benefits under this provision will remain subject to the Restoration of Benefits provision.

If Disability is caused by more than one Injury, We will pay benefits as if it was caused by only one injury. We will not pay more than the Disability Income Benefit Period for any one Period of Disability.

Disability starts on the date of the first treatment by a Doctor for the Disability. Disability is considered to continue, and the Monthly Disability Income Benefit will be paid, only while the Covered Person is under the care of a Doctor for the cause of the Disability. The Doctor must state in writing that the Covered Person continues to be Disabled.

The Disability Income Benefit under this policy ends and a corresponding reduction in premium will be made for each applicable Covered Person upon the first policy anniversary which follows his or her sixty-fifth (65th) birthday. However, any Disability that begins prior to a Covered Person's sixty-fifth (65th) birthday will continue, up to any benefit payments remaining in the Disability Income Benefit Period.

RESTORATION OF BENEFITS: After a Covered Person has received the Maximum Disability Income Benefit payments, benefits will be fully restored after forty-eight (48) consecutive months have elapsed from the last date of the last Monthly Disability Income Benefit payment. Once benefits are restored, any new Disability incurred must be as a result of a new Injury.

EXCLUSIONS

This Policy does not provide benefits for:

- Treatment, services or supplies which:
 - Are not Medically Necessary;
 - Are not prescribed by a Doctor as necessary to treat an Injury;
 - Are determined to be Experimental/Investigational in nature;
 - Are received without charge or legal obligation to pay;
- Intentionally self-inflicted Injury, violating or attempting to violate any duly enacted law.
- Injury by acts of war, whether declared or not.
- Injury received while traveling or flying by air, except as a fare-paying passenger on a regularly scheduled commercial airline.
- Dental treatment, except as specifically stated.
- Treatment of Sickness, disease or infections, except pyogenic infections or bacterial infections which result from the accidental ingestion of contaminated substances.
- Suicide or attempted suicide while sane; or self-destruction or an attempt to self-destroy while insane.
- Injury sustained while committing or attempting to commit a felony.
- Injury sustained while voluntarily participating in a riot or civil commotion or disturbance of any kind.
- Loss occurring while the Covered Person is incarcerated if the incarceration is during a period of legal incarceration in a penal or correctional institution of more than seven (7) days or during a period of legal detainment of more than seven (7) days.
- Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay.
- 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.
- Loss resulting from an Accident where the Covered Person is the operator of a motor vehicle and did not possess a current and valid driver's license to operate that class of vehicle at the time of the Accident.
- Loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a Doctor.
- Injury which occurs while a Covered Person is on active duty service in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond thirty-one (31) days.
- Cosmetic surgery, except for reconstructive surgery on an injured part of the body.
- Loss resulting from competing in motor sport or water sport races or competitions.
- Loss resulting from testing cars/trucks on any racetrack or speedway.
- Loss resulting from handling, storing or transporting explosives.

EXCLUSIONS (Continued)

- Loss resulting from spelunking (exploring caves); or scaling up or down cliffs or mountain walls.
- Loss resulting from practice for or participation in a rodeo.
- Injury sustained flying in an ultra light, hang gliding, parachuting, bungee cord jumping.
- Injuries incurred outside of the United States or its possessions, unless such loss is incurred while the Covered Person is on a trip of not more than 60 days.

PREMIUM AND REINSTATEMENT

Payment of Premium. The first premium on Your policy is payable on the Effective Date. After that, premiums are payable in the amount and mode shown on the Policy Schedule. Payments may be made at Our Home Office in Glenview, IL

If We accept a premium, this Policy will continue in force until the end of the term for which that premium was due.

The amount of the first premium is shown in the Policy Schedule and is based on Your initial mode of payment. The amount of each premium after the first is based on Your then current mode of payment and the premium then being charged for policies of this form number and premium classification issued in the same state.

Grace Period. This Policy has a grace period of thirty-one (31) days for paying a premium. During the grace period, this Policy will remain in force. If a premium is not paid during the grace period, this Policy will terminate as of the due date of the premium.

Reinstatement. If a premium is not paid before the grace period ends, this Policy will lapse. Later acceptance of a premium by Us without asking for an application for reinstatement will reinstate this Policy as of 12:01 (Standard Time) on the day after the date We receive the premium.

If You are asked for an application, a conditional receipt for the premium will be given to You. If the application is approved, this Policy will be reinstated as of 12:01 (Standard Time) on the day after the date the reinstatement application is approved. Lacking such approval, this Policy will be reinstated on the 45th day after the date of the receipt unless We write You of Our disapproval before that date.

If reinstated, this Policy will only cover loss sustained after the date of reinstatement. In all other ways, Your rights and Ours will remain the same subject to any provision of the reinstatement. Premium will be applied as of the date of reinstatement.

Refund of Premium: We will refund that part of any premium paid beyond the end of the month in which Your death occurred. Payment will be made within 30 days after Our receipt of proof of Your death.

CLAIM PROVISIONS

Notice of Claim. Written notice of claim must be sent to Us at Our Home Office or to an authorized agent within thirty (30) days after the start of a loss. Such notice must include Your name and policy number. If notice cannot be given within that time, You must send the notice as soon as reasonably possible.

Claim Forms: When We receive notice of a claim, We will send forms for filing Proof of Loss. If We do not send these forms within fifteen (15) days, You will meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time stated in the Proof of Loss section.

Proof of Loss. Written Proof of Loss must be given to Us within ninety (90) days of such loss. If it was not reasonably possible to give Us written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. Unless You are legally unable to act, proof must be sent no later than one (1) year after the time specified.

Payment of Claims. When We receive written proof of loss covered by this Policy, We will pay any benefits due to You or else to Your beneficiary.

You are the beneficiary of all other Covered Persons. Your beneficiary is Your spouse, if living, otherwise Your surviving children; otherwise Your estate. Only You have the right to change Your beneficiary.

If benefits are payable to Your estate or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay up to \$1,000 to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

CLAIM PROVISIONS (Continued)

Time of Payment of Claims. After We receive satisfactory written proof of loss:

1. We will pay any benefits then due that are not payable periodically; and
2. We will pay at the end of each thirty (30) days any benefits due that are payable periodically, subject to continuing proof of loss.

Physical Examination and Autopsy. We, at Our own expense, have the right to have a Doctor of Our choice examine a Covered Person as often as reasonably necessary while a claim is pending. We may also have an autopsy made unless prohibited by law.

Assignment. Unless it is in writing and sent to Us at Our Home Office, no assignment of this Policy or its benefits, by You or Your legal representative will affect Us. We are not responsible for the validity of the assignment. Any payment We make in good faith will end Our liability to the extent of the payment.

Legal Action. No legal action may be brought to recover on this Policy until sixty (60) days after written proof of loss has been given as required. No such action may be brought after three (3) years from the time written proof of loss was required to be given.

GENERAL PROVISIONS

Entire Contract Changes. This policy with the application and attached papers is the entire contract between You and Us. No change in this Policy will be effective until approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

Misstatement of Age: If the age of a Covered Person has been misstated, the benefits will be those the premium paid would have purchased at the correct age. If the correct age is such that We would not have insured the person under this Policy, or such that the coverage would have terminated, We will refund all premiums paid for the period not covered, and We will not pay any claims incurred during that period.

Term. The first term begins at 12:01 a.m. (Standard Time) on the Effective Date shown on the policy schedule, but insurance will not be effective prior to the time the application is signed by the applicant. The first term ends at 12:00 midnight (Standard Time) on the First Renewal Date. Each renewal term begins at 12:01 a.m. (Standard Time) on the day after the date to which premium is paid. Renewal dates are determined by Your mode of payment. Your initial mode of payment is shown in the Policy Schedule

Time Limit on Certain Defenses. We rely on the statements made in the application when issuing this insurance. After this insurance has been in force for two (2) years, only fraudulent misstatements in the application may be used to void this Policy or deny any claim for loss which starts after the two (2) year period.

Conformity with State Statutes. Any provision of this Policy which, on the Effective Date, is in conflict with the laws of the State in which You reside is amended to conform to the minimum requirements of those laws.

Annual Meeting: The annual meeting of Our Policyholders will be held in Our home office. It will start at 10:00 a.m. on the first Monday in July. It will be held on Tuesday if Monday is a legal holiday. We will elect Directors and transact other business that is brought before the meeting.

BENEFITS SCHEDULE – PLAN A

This is a summary of Benefits. Please read your entire policy for further explanations and limitations.

ACCIDENT BENEFITS

Hospital Confinement

Daily Benefit Amount days 1 through 90	\$100/day
Daily Benefit Amount beginning with the 91 st consecutive day through 365 th day	\$200/day

First Occurrence Confinement \$500 Per Accident, Up To 2 Payments Per Calendar Year

Ambulance

Ground	\$250 Per Accident, Up to 4 Payments Per Calendar Year
Air Transport	\$1,000 Per Accident and Per Calendar Year

Emergency Room \$100 Per Accident, Up To 4 Payments Per Calendar Year

Emergency Medical / Dental / Chiropractic \$25 Per Visit
Limited To A Combined Total of Six Visits Per Calendar Year For All Medical, Dental and Chiropractic Visits

Outpatient Therapy \$50 Per Visit
Limited to a Combined Total of Six Visits For All Covered Therapies Per Accident

Surgical Procedures - Limited To One Payment Per Accident
Outpatient \$250

Fracture

See Fractures Schedule, Limit One Payment Per Accident, Up To 4 Payments Per Calendar Year

Prosthesis \$2,000, One Prosthetic Per Accident

Accidental Death Benefit – Primary Insured \$15,000

[Accidental Death Benefit – Dependent Spouse \$15,000]

[Accidental Death Benefit – Dependent Child \$ 2,000]

Accidental Dismemberment:

A. Loss of Both Hands, Both Feet, or Sight in Both Eyes:	\$10,000
B. Loss of One Hand, One Foot, or Sight in One Eye:	\$ 5,000
C. Loss of One or More Fingers and/or Toes:	\$ 500
Maximum Payout Per Accident (A, B, and C)	\$20,000

DISABILITY INCOME BENEFITS

Monthly Disability Income Benefit:	\$500
Maximum Disability Income Benefits:	up to, 12 Months
Disability Income Benefit Period Per Period of Disability:	up to, 6 months
Elimination Period Per Period of Disability:	90 Consecutive Days

BENEFIT SCHEDULE PLAN A (Continued)

FRACTURE BENEFIT SCHEDULE

If more than one fracture is sustained as a result of Injury, we will pay the highest benefit amount associated with the sustained fracture. If the fracture sustained is not shown in this Benefit Schedule, we will pay the benefit amount most comparable (from the list below) for such fracture.

Fracture Type	Benefit Amount (Open/Compound Fracture)	Benefit Amount (Closed Fracture)
Skull (depressed)	\$2,500	\$1,250
Skull (simple)	\$1,000	\$ 500
Hip/Thigh	\$1,500	\$ 750
Leg	\$ 800	\$ 400
Foot/Ankle/Kneecap	\$ 300	\$ 150
Vertebrae (body) or Pelvis (excluding Coccyx)	\$ 800	\$ 400
Vertebrae Processes	\$ 300	\$ 150
Coccyx	\$ 200	\$ 100
Upper Jaw, Upper Arm or Face (excluding nose)	\$ 350	\$ 175
Lower Jaw (mandible)	\$ 300	\$ 150
Shoulder Blade or Collarbone	\$ 300	\$ 150
Wrist, Forearm or Hand (excluding fingers)	\$ 300	\$ 150
Rib	\$ 250	\$ 125

BENEFITS SCHEDULE – PLAN B

This is a summary of Benefits. Please read your entire policy for further explanations and limitations.

ACCIDENT BENEFITS

Hospital Confinement

Daily Benefit Amount days 1 through 90 \$200/day
Daily Benefit Amount beginning with the 91st consecutive day through 365th day \$400/day

First Occurrence Confinement \$1,000 Per Accident, Up To 2 Payments Per Calendar Year

Ambulance

Ground \$250 Per Accident, Up to 4 Payments Per Calendar Year
Air Transport \$1,000 Per Accident and Per Calendar Year

Emergency Room \$200 Per Accident, Up To 4 Payments Per Calendar Year

Emergency Medical / Dental / Chiropractic \$25 Per Visit
Limited To A Combined Total of Six Visits Per Calendar Year For All Medical, Dental and Chiropractic Visits

Outpatient Therapy \$50 Per Visit
Limited to a Combined Total of Six Visits For All Covered Therapies Per Accident

Surgical Procedures - Limited To One Payment Per Accident
Outpatient \$500

Fracture

See Fractures Schedule, Limit One Payment Per Accident, Up To 4 Payments Per Calendar Year

Prosthesis \$4,000, One Prosthetic Per Accident

Accidental Death Benefit – Primary Insured \$30,000

[Accidental Death Benefit – Dependent Spouse \$30,000]

[Accidental Death Benefit – Dependent Child \$ 4,000]

Accidental Dismemberment:

A. Loss of Both Hands, Both Feet, or Sight in Both Eyes: \$20,000
B. Loss of One Hand, One Foot, or Sight in One Eye: \$10,000
C. Loss of One or More Fingers and/or Toes: \$1,000
Maximum Payout Per Accident (A, B, and C) \$40,000

DISABILITY INCOME BENEFITS

Monthly Disability Income Benefit: \$1,000
Maximum Disability Income Benefits: up to, 12 Months
Disability Income Benefit Period Per Period of Disability: up to, 6 months
Elimination Period Per Period of Disability: 90 Consecutive Days

BENEFIT SCHEDULE PLAN B (Continued)

FRACTURE BENEFIT SCHEDULE

If more than one fracture is sustained as a result of Injury, we will pay the highest benefit amount associated with the sustained fracture. If the fracture sustained is not shown in this Benefit Schedule, we will pay the benefit amount most comparable (from the list below) for such fracture.

Fracture Type	Benefit Amount (Open/Compound Fracture)	Benefit Amount (Closed Fracture)
Skull (depressed)	\$5,000	\$2,500
Skull (simple)	\$2,000	\$1,000
Hip/Thigh	\$3,000	\$1,500
Leg	\$1,600	\$ 800
Foot/Ankle/Kneecap	\$ 600	\$ 300
Vertebrae (body) or Pelvis (excluding Coccyx)	\$1,600	\$ 800
Vertebrae Processes	\$ 600	\$ 300
Coccyx	\$ 400	\$ 200
Upper Jaw, Upper Arm or Face (excluding nose)	\$ 700	\$ 350
Lower Jaw (mandible)	\$ 600	\$ 300
Shoulder Blade or Collarbone	\$ 600	\$ 300
Wrist, Forearm or Hand (excluding fingers)	\$ 600	\$ 300
Rib	\$ 500	\$ 250

BENEFITS SCHEDULE – PLAN C

This is a summary of Benefits. Please read your entire policy for further explanations and limitations.

ACCIDENT BENEFITS

Hospital Confinement

Daily Benefit Amount days 1 through 90	\$300/day
Daily Benefit Amount beginning with the 91 st consecutive day through 365 th day	\$600/day

First Occurrence Confinement \$1,500 Per Accident, Up To 2 Payments Per Calendar Year

Ambulance

Ground	\$250 Per Accident, Up to 4 Payments Per Calendar Year
Air Transport	\$1,000 Per Accident and Per Calendar Year

Emergency Room \$300 Per Accident, Up To 4 Payments Per Calendar Year

Emergency Medical / Dental / Chiropractic \$25 Per Visit
Limited To A Combined Total of Six Visits Per Calendar Year For All Medical, Dental and Chiropractic Visits

Outpatient Therapy \$100 Per Visit
Limited to a Combined Total of Six Visits For All Covered Therapies Per Accident

Surgical Procedures - Limited To One Payment Per Accident
Outpatient \$750

Fracture

See Fractures Schedule, Limit One Payment Per Accident, Up To 4 Payments Per Calendar Year

Prosthesis \$6,000, One Prosthetic Per Accident

Accidental Death Benefit – Primary Insured \$45,000
[Accidental Death Benefit – Dependent Spouse \$45,000]
[Accidental Death Benefit – Dependent Child \$ 6,000]

Accidental Dismemberment:

A. Loss of Both Hands, Both Feet, or Sight in Both Eyes:	\$30,000
B. Loss of One Hand, One Foot, or Sight in One Eye:	\$15,000
C. Loss of One or More Fingers and/or Toes:	\$1,500
Maximum Payout Per Accident (A, B, and C)	\$60,000

DISABILITY INCOME BENEFITS

Monthly Disability Income Benefit: \$2,000
Maximum Disability Income Benefits: up to, 12 Months
Disability Income Benefit Period Per Period of Disability: up to, 6 months
Elimination Period Per Period of Disability: 90 Consecutive Days

BENEFIT SCHEDULE PLAN C (Continued)

FRACTURE BENEFIT SCHEDULE

If more than one fracture is sustained as a result of Injury, we will pay the highest benefit amount associated with the sustained fracture. If the fracture sustained is not shown in this Benefit Schedule, we will pay the benefit amount most comparable (from the list below) for such fracture.

Fracture Type	Benefit Amount (Open/Compound Fracture)	Benefit Amount (Closed Fracture)
Skull (depressed)	\$7,500	\$3,750
Skull (simple)	\$3,000	\$1,500
Hip/Thigh	\$4,500	\$2,250
Leg	\$2,400	\$1,200
Foot/Ankle/Kneecap	\$ 900	\$ 450
Vertebrae (body) or Pelvis (excluding Coccyx)	\$2,400	\$1,200
Vertebrae Processes	\$ 900	\$ 450
Coccyx	\$ 600	\$ 300
Upper Jaw, Upper Arm or Face (excluding nose)	\$1,050	\$ 525
Lower Jaw (mandible)	\$ 900	\$ 450
Shoulder Blade or Collarbone	\$ 900	\$ 450
Wrist, Forearm or Hand (excluding fingers)	\$ 900	\$ 450
Rib	\$ 750	\$ 375

BENEFITS SCHEDULE – PLAN D

This is a summary of Benefits. Please read your entire policy for further explanations and limitations.

ACCIDENT BENEFITS

Hospital Confinement

Daily Benefit Amount days 1 through 90 \$400/day
Daily Benefit Amount beginning with the 91st consecutive day through 365th day \$800/day

First Occurrence Confinement \$2,000 Per Accident, Up To 2 Payments Per Calendar Year

Ambulance

Ground \$250 Per Accident, Up to 4 Payments Per Calendar Year
Air Transport \$1,000 Per Accident and Per Calendar Year

Emergency Room \$400 Per Accident, Up To 4 Payments Per Calendar Year

Emergency Medical / Dental / Chiropractic \$25 Per Visit
Limited To A Combined Total of Six Visits Per Calendar Year For All Medical, Dental and Chiropractic Visits

Outpatient Therapy \$100 Per Visit
Limited to a Combined Total of Six Visits For All Covered Therapies Per Accident

Surgical Procedures - Limited To One Payment Per Accident

Outpatient \$1,000

Fracture

See Fractures Schedule, Limit One Payment Per Accident, Up To 4 Payments Per Calendar Year

Prosthesis \$8,000, One Prosthetic Per Accident

Accidental Death Benefit – Primary Insured \$60,000

[Accidental Death Benefit – Dependent Spouse \$60,000]

[Accidental Death Benefit – Dependent Child \$ 8,000]

Accidental Dismemberment:

A. Loss of Both Hands, Both Feet, or Sight in Both Eyes: \$40,000
B. Loss of One Hand, One Foot, or Sight in One Eye: \$20,000
C. Loss of One or More Fingers and/or Toes: \$2,000
Maximum Payout Per Accident (A, B, and C) \$80,000

DISABILITY INCOME BENEFITS

Monthly Disability Income Benefit: \$2,000
Maximum Disability Income Benefits: up to, 12 Months
Disability Income Benefit Period Per Period of Disability: up to, 6 months
Elimination Period Per Period of Disability: 90 Consecutive Days

BENEFIT SCHEDULE PLAN D (Continued)

FRACTURE BENEFIT SCHEDULE

If more than one fracture is sustained as a result of Injury, we will pay the highest benefit amount associated with the sustained fracture. If the fracture sustained is not shown in this Benefit Schedule, we will pay the benefit amount most comparable (from the list below) for such fracture.

Fracture Type	Benefit Amount (Open/Compound Fracture)	Benefit Amount (Closed Fracture)
Skull (depressed)	\$10,000	\$5,000
Skull (simple)	\$ 4,000	\$2,000
Hip/Thigh	\$ 6,000	\$3,000
Leg	\$ 3,200	\$1,600
Foot/Ankle/Kneecap	\$ 1,200	\$ 600
Vertebrae (body) or Pelvis (excluding Coccyx)	\$ 3,200	\$1,600
Vertebrae Processes	\$ 1,200	\$ 600
Coccyx	\$ 800	\$ 400
Upper Jaw, Upper Arm or Face (excluding nose)	\$ 1,400	\$ 700
Lower Jaw (mandible)	\$ 1,200	\$ 600
Shoulder Blade or Collarbone	\$ 1,200	\$ 600
Wrist, Forearm or Hand (excluding fingers)	\$ 1,200	\$ 600
Rib	\$ 1,000	\$ 500

BENEFITS SCHEDULE – PLAN E

This is a summary of Benefits. Please read your entire policy for further explanations and limitations.

ACCIDENT BENEFITS

Hospital Confinement

Daily Benefit Amount days 1 through 90 \$500/day
Daily Benefit Amount beginning with the 91st consecutive day through 365th day \$1,000/day

First Occurrence Confinement \$2,500 Per Accident, Up To 2 Payments Per Calendar Year

Ambulance

Ground \$250 Per Accident, Up to 4 Payments Per Calendar Year
Air Transport \$1,000 Per Accident and Per Calendar Year

Emergency Room \$500 Per Accident, Up To 4 Payments Per Calendar Year

Emergency Medical / Dental / Chiropractic

\$25 Per Visit

Limited To A Combined Total of Six Visits Per Calendar Year For All Medical, Dental and Chiropractic Visits

Outpatient Therapy

\$100 Per Visit

Limited to a Combined Total of Six Visits For All Covered Therapies Per Accident

Surgical Procedures - Limited To One Payment Per Accident

Outpatient \$1,250

Fracture

See Fractures Schedule, Limit One Payment Per Accident, Up To 4 Payments Per Calendar Year

Prosthesis

\$10,000, One Prosthetic Per Accident

Accidental Death Benefit – Primary Insured

\$75,000

[Accidental Death Benefit – Dependent Spouse

\$75,000]

[Accidental Death Benefit – Dependent Child

\$10,000]

Accidental Dismemberment:

A. Loss of Both Hands, Both Feet, or Sight in Both Eyes: \$50,000

B. Loss of One Hand, One Foot, or Sight in One Eye: \$25,000

C. Loss of One or More Fingers and/or Toes: \$2,500

Maximum Payout Per Accident (A, B, and C) \$100,000

DISABILITY INCOME BENEFITS

Monthly Disability Income Benefit:

\$2,500

Maximum Disability Income Benefits:

up to, 12 Months

Disability Income Benefit Period Per Period of Disability:

up to, 6 months

Elimination Period Per Period of Disability:

90 Consecutive Days

BENEFIT SCHEDULE PLAN E (Continued)

FRACTURE BENEFIT SCHEDULE

If more than one fracture is sustained as a result of Injury, we will pay the highest benefit amount associated with the sustained fracture. If the fracture sustained is not shown in this Benefit Schedule, we will pay the benefit amount most comparable (from the list below) for such fracture.

Fracture Type	Benefit Amount (Open/Compound Fracture)	Benefit Amount (Closed Fracture)
Skull (depressed)	\$12,500	\$6,250
Skull (simple)	\$ 5,000	\$2,500
Hip/Thigh	\$ 7,500	\$3,750
Leg	\$ 4,000	\$2,000
Foot/Ankle/Kneecap	\$ 1,500	\$ 750
Vertebrae (body) or Pelvis (excluding Coccyx)	\$ 4,000	\$2,000
Vertebrae Processes	\$ 1,500	\$ 750
Coccyx	\$ 1,000	\$ 500
Upper Jaw, Upper Arm or Face (excluding nose)	\$ 1,750	\$ 875
Lower Jaw (mandible)	\$ 1,500	\$ 750
Shoulder Blade or Collarbone	\$ 1,500	\$ 750
Wrist, Forearm or Hand (excluding fingers)	\$ 1,500	\$ 750
Rib	\$ 1,250	\$ 625

**GUARANTEE TRUST LIFE
INSURANCE COMPANY**

A Mutual Company
1275 Milwaukee Avenue
Glenview, Illinois 60025
(847) 699-0600

**ACCIDENT ONLY
POLICY**

Includes Limited Benefits
For Disability Income

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
(847) 699-0600

RETURN OF PREMIUM UPON DEATH BENEFIT RIDER

EFFECTIVE DATE: _____

This Rider is a part of the Policy to which it is attached. It is issued in consideration of the application and payment of the required premium. It takes effect on the Effective Date shown above at 12:01 a.m. Standard Time where You live. If no date is shown above, it begins on the policy's Effective Date.

RETURN OF PREMIUM BENEFIT

In the event You die before the first Policy anniversary which follows Your eightieth (80th) birthday, a Return of Premium Benefit may be payable to Your named beneficiary or estate. Benefit payment under this Rider is subject to the Policy being in force with this Rider at the time of Your death.

The actual amount of premium that will be returned, if any, will equal:

1. The sum of all premiums You paid for the Policy, including premiums paid for this Rider and any other benefit Rider(s) attached to the Policy (unless expressly excluded), while this Rider was in force (except for any application and annual policy fees). Premium also includes premiums paid for any Dependent(s) insured under the Policy. The sum of all premiums is without interest accumulation. MINUS
2. The sum of all benefits paid or then payable under the Policy, including benefits paid or payable under any attached benefit Riders, to You or on Your behalf while this Rider was in force.

If We receive a claim for benefits after proceeds have been paid under the terms of this Rider, the amount of claim benefits due, if any, will be reduced by the amount of the Return of Premium Upon Death Benefit that has already been paid.

CLAIM PROVISIONS

Proof of Death: Any benefits payable under the terms of this Rider will be paid when We receive completed proof of claim forms along with a certified copy of the insured's death certificate. Such proof should be sent to Our Home Office within ninety (90) days of the date of death, but no later than one (1) year from date of death. Claim forms will be made available to the beneficiary upon request.

Benefit Payment: Any benefit due will be paid in a lump sum within ninety (90) days of Our receipt of the due written proof of death. Benefits will be paid according to any beneficiary designation in effect at time of payment. If none is then in effect, We'll pay benefits as follows: (a) to Your spouse, if living, otherwise (b) equally to Your then living lawful children, including stepchildren and adopted children, if any, otherwise (c) to Your estate.

If benefits are payable to Your estate or a beneficiary who can't give a valid release, We can pay up to one-thousand dollars (\$1,000) to anyone related to You or Your beneficiary by blood or marriage, whom We consider to be entitled to the benefits. We'll be discharged to the extent of any such payment made in good faith.

RENEWAL CONDITIONS

This Rider is renewed when the policy to which it is attached is renewed.

PREMIUM

This Rider requires the payment of premium in addition to the premium due for the Policy. The premium for this benefit Rider is shown in the Policy schedule.

We can change the premium for this Rider if We change it for all riders like Yours in Your state on a class basis. If a premium change is needed, We'll provide You with advance written notice in the time required by Your state.

RIDER TERMINATION

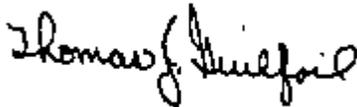
This Rider ends on the earlier of:

- a. When the Policy to which it is attached ends; or
- b. The first Policy anniversary which immediately follows Your eightieth (80th) birthday.

CONDITIONS

This Rider is subject to all terms, provisions, limitations and exclusions of the Policy except where specifically changed by this Rider.

Signed for Guarantee Trust Life Insurance Company at Glenview, Illinois by



Secretary



President

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
(847) 699-0600

RETURN OF PREMIUM BENEFIT RIDER
(Payable Upon Completion of the Return of Premium Period)

EFFECTIVE DATE: _____

This Rider is a part of the Policy to which it is attached. It is issued in consideration of the application and payment of the required premium. It takes effect on the Effective Date shown above at 12:01 a.m. Standard Time where you live. If no date is shown above, it begins on the policy's Effective Date.

DEFINITION(S)

Return of Premium Period: That period of time after which a Return of Premium benefit may be due. The Return of Premium Period begins on the Effective Date of this Rider and ends upon the full completion of the number of years shown on the Policy Schedule for this benefit.

RETURN OF PREMIUM BENEFIT

This Rider may provide for a Return of Premium Benefit in the event Your Policy remains in force until the end of the Return of Premium Period.

The actual amount of premium that will be returned, if any, will be equal to:

1. For Issue Ages Fifty-Nine (59) and Under: One-hundred percent (100%) of all premiums You paid for the Policy.
For Issue Ages Sixty (60) and Above: Eighty percent (80%) of all premiums You paid for the Policy.

Premium paid for the Policy includes premiums paid for this Rider and any other benefit Rider(s) attached to the Policy (unless expressly excluded), while this Rider was in force (except for any application and annual policy fees). Premium also includes premiums paid for any Dependent(s) insured under the Policy. The sum of all premiums is without interest accumulation.

2. From the sum of all premiums paid in #1, above, we will subtract all benefits paid or then payable under the Policy for You or any Dependent(s) insured under the Policy. Benefits include those paid or payable under any attached benefit Riders, to you or on your behalf while this Rider was in force.

If we receive a claim for benefits after proceeds have been paid under the terms of this Rider, the amount of claim benefits due, if any, will be reduced by the amount of the Return of Premium Benefit that has already been paid.

RENEWAL CONDITIONS

This Rider is renewed when the policy to which it is attached is renewed.

At the end of the Return of Premium Period, You will have the option to renew this Rider. Renewal will be conditioned upon the new Return of Premium Period beginning before Your attained age seventy-six (76). If renewed, the renewal premium of this Rider will be at Your attained age at the start of the new Return of Premium Period.

LAPSE AND REINSTATEMENT

If You allow the Policy to lapse and it is later reinstated, then the Return of Premium Period will be deferred by the period of time the Policy and this Rider were inactive.

PREMIUM

This Rider requires the payment of premium in addition to the premium due for the Policy. The premium for this benefit Rider is shown in the Policy schedule.

We can change the premium for this Rider if we change it for all riders like yours in your state on a class basis. If a premium change is needed, we'll provide you with advance written notice in the time required by your state.

RIDER TERMINATION

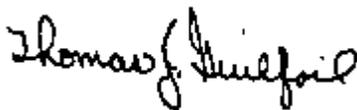
This Rider ends on the earlier of:

- a. When the Policy to which it is attached ends; or
- b. The end of the Return of Premium Period, unless You choose to renew this Rider, as stated under the Renewal Conditions provision.

CONDITIONS

This Rider is subject to all terms, provisions, limitations and exclusions of the Policy except where specifically changed by this Rider.

Signed for Guarantee Trust Life Insurance Company at Glenview, Illinois by



Secretary



President

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

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

A. APPLICANT(S) INFORMATION

A P P L	1. Last Name _____		First Name _____		M.I. _____	
	Soc. Sec # _____	Sex _____	Age _____	Birth Date _____		
S P O U S E	2. Last Name _____		First Name _____		M.I. _____	
	Sex _____	Age _____	Birth Date _____			
D E P E N D E N T S	D1. Last Name _____		First Name _____		M.I. _____	Sex _____
					Age _____	Birth Date _____
	D2. Last Name _____		First Name _____		M.I. _____	Sex _____
					Age _____	Birth Date _____
	D3. Last Name _____		First Name _____		M.I. _____	Sex _____
				Age _____	Birth Date _____	
D4. Last Name _____		First Name _____		M.I. _____	Sex _____	
				Age _____	Birth Date _____	
D5. Last Name _____		First Name _____		M.I. _____	Sex _____	
				Age _____	Birth Date _____	
<i>For additional dependents, please attach a separate piece of paper, signed by the applicant, including the above information for each dependent.</i>						
A D D R E S S	3. Street Address _____					
	City _____		State _____		Zip Code _____	
	County _____		Township _____		Section _____	
	Telephone (Primary) _____			E-Mail Address _____		

B. COVERAGE SELECTION & PREMIUMS

<p>1. Benefit Plan — Primary:</p> <table style="width:100%; text-align:center;"> <tr> <td><input type="checkbox"/> A</td> <td><input type="checkbox"/> B</td> <td><input type="checkbox"/> C</td> <td><input type="checkbox"/> D</td> <td><input type="checkbox"/> E</td> </tr> <tr> <td>\$500</td> <td>\$1,000</td> <td>\$1,500</td> <td>\$2,000</td> <td>\$2,500</td> </tr> </table> <p align="center">(Includes Return of Premium Benefit Rider)</p> <p>2. Benefit Plan — Spouse:</p> <table style="width:100%; text-align:center;"> <tr> <td><input type="checkbox"/> A</td> <td><input type="checkbox"/> B</td> <td><input type="checkbox"/> C</td> <td><input type="checkbox"/> D</td> <td><input type="checkbox"/> E</td> </tr> <tr> <td>\$500</td> <td>\$1,000</td> <td>\$1,500</td> <td>\$2,000</td> <td>\$2,500</td> </tr> </table> <p>3. Benefit Plan — Dependents:</p> <table style="width:100%; text-align:center;"> <tr> <td><input type="checkbox"/> A</td> <td><input type="checkbox"/> B</td> <td><input type="checkbox"/> C</td> <td><input type="checkbox"/> D</td> <td><input type="checkbox"/> E</td> </tr> <tr> <td>\$500</td> <td>\$1,000</td> <td>\$1,500</td> <td>\$2,000</td> <td>\$2,500</td> </tr> </table>	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> E	\$500	\$1,000	\$1,500	\$2,000	\$2,500	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> E	\$500	\$1,000	\$1,500	\$2,000	\$2,500	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> E	\$500	\$1,000	\$1,500	\$2,000	\$2,500	<p>4. Premium Payment Mode: <i>Select One From Below: Select One From Below:</i></p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Bank Draft</td> <td><input type="checkbox"/> Monthly (N/A for Direct Billing)</td> </tr> <tr> <td><input type="checkbox"/> Credit Card</td> <td><input type="checkbox"/> Quarterly</td> </tr> <tr> <td><input type="checkbox"/> Direct Bill</td> <td><input type="checkbox"/> Semi Annual</td> </tr> <tr> <td></td> <td><input type="checkbox"/> Annual</td> </tr> </table> <p>Draft/Bill Date: _____</p> <p>5. Modal Premiums:</p> <p>Primary: _____</p> <p>Spouse: _____</p> <p>Dependent: _____ x # _____ = _____</p> <p>Total: _____</p> <p>6. Beneficiary Designation</p> <p>Applicant: _____ Relationship _____</p> <p>Spouse: _____ Relationship _____</p>	<input type="checkbox"/> Bank Draft	<input type="checkbox"/> Monthly (N/A for Direct Billing)	<input type="checkbox"/> Credit Card	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Semi Annual		<input type="checkbox"/> Annual
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<input type="checkbox"/> Credit Card	<input type="checkbox"/> Quarterly																																						
<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Semi Annual																																						
	<input type="checkbox"/> Annual																																						

C. PRE-QUALIFICATION, MEDICAL INFORMATION & EXCLUSIONS

Has any person applying for coverage:

1. In the past 12 months been:
 - a. Confined to a hospital as an inpatient due to an accident related injury?
 - b. Disabled or received any disability payments?
 - c. Prescribed medication or had surgery, or recommended surgery, or undergone therapy for a back, neck or joint disorder?
2. In the past 5 years been treated for or diagnosed by a member of the medical profession as having:
 - a. Osteoporosis, Parkinson's disease, epilepsy or seizure disorder, paralysis, or fainting spells or blackouts?
 - b. Alzheimer's disease, multiple sclerosis, or alcohol or drug abuse?
3. In the past 3 years participated or intend to participate in flying as a private pilot or crew member, skydiving, parachuting, hang gliding, organized racing, mountain climbing, or bungee jumping?

APPLICANT'S ANSWER: Yes No (If yes, do not submit the application)

SPOUSE'S ANSWER: Yes No (If yes, the spouse does not qualify for this plan)

DEPENDENT 1 ANSWER: Yes No (If yes, dependent does not qualify for this plan)

DEPENDENT 2 ANSWER: Yes No (If yes, dependent does not qualify for this plan)

DEPENDENT 3 ANSWER: Yes No (If yes, dependent does not qualify for this plan)

DEPENDENT 4 ANSWER: Yes No (If yes, dependent does not qualify for this plan)

DEPENDENT 5 ANSWER: Yes No (If yes, dependent does not qualify for this plan)

Question #4 must be completed if the applicant (and spouse, if applying for coverage) are under age 65.

4. 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 12 months?

Applicant's answer Yes No (If "No", do not submit the application)

Occupation: _____

Spouse's answer Yes No (If "No", the spouse does not qualify for this plan)

Occupation: _____

D. COVERAGE INFORMATION

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.) If "YES," with which company? _____ Policy Number: _____	Applicant <input type="checkbox"/> Yes <input type="checkbox"/> No	Spouse <input type="checkbox"/> Yes <input type="checkbox"/> No

E. AGENT'S STATEMENT

I certify that I have accurately recorded the information supplied by the Applicant(s). 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. (Section E is not required if agent is not present.)

Agent's Name (Printed)

Agent Code

Agent's Signature

Date

E-mail Address

MAIL POLICY TO: Agent Applicant

ACKNOWLEDGEMENTS & AUTHORIZATION

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 or my spouse's health conditions or that of my (our) dependents (if applying for spouse and dependent coverage), from the date of this application until insurance becomes effective, may result in the declination of coverage. No agent or other representative of GTL has required, permitted, or encouraged me 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, and if applicable, the Guide to Health Insurance for people with Medicare and the outline of coverage. I (We) understand that insurance applied for will not become effective until: (a) approved and issued by GTL; (b) I (we) have been furnished written notice of the effective date; and (c) premiums have been paid in full.

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 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 the Company's 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.

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.

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

Signed at _____
Date City and State

Applicant Signature Spouse Signature (if applicable)

PLEASE DETACH AND GIVE TO PROPOSED INSURED

PRE-NOTICE TO PROPOSED INSURED

I understand that the insurance applied for shall not become effective until: a) approved and issued by GTL; and b) I have been furnished written notice of the effective date.

DO NOT CANCEL EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE OF APPROVAL FROM GTL

In completing this application for insurance, it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties such as family members; business associates; financial sources; friends; neighbors; or others with whom you are acquainted. This inquiry includes information as to your character; general reputation; personal characteristics; and mode of living, whichever may be applicable. You have the right to make written request within a reasonable time period for a disclosure of additional information concerning the nature and scope of the investigation. (See Disclosure Notice.)

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 thereon to the Medical Information Bureau, a not-for-profit membership organization of life 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, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address to the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. 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.

NOTICE OF INFORMATION PRACTICES

GTL will need to obtain data about you and other persons proposed for insurance prior to issuing your coverage. Some data will be obtained from you and some from other sources. That data and any data that is collected at a later date, may in some cases be disclosed to third parties without your specific consent subject to the Company's privacy policies. You have the right of access and correction to data received about you. But, data about a claim or a civil or criminal proceeding is excepted. Details on these procedures will be furnished on request.

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

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 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 #: _____ 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 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 further 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

Credit Card Authorization
Not applicable if paying by check or money order

Name (on card) _____

Billing Address _____

Phone Number _____

Card Type Visa Master Card Discover

Card Number _____

Expiration Date _____

I authorize Guarantee Trust Life Insurance Company to bill my VISA / MASTERCARD/ DISCOVER for 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 _____

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

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

A. APPLICANT(S) INFORMATION

A P P L	1. Last Name _____ First Name _____ M.I. _____					
	Soc. Sec # _____		Sex _____	Age _____	Birth Date _____	
S P O U S E	2. Last Name _____ First Name _____ M.I. _____					
	Sex _____		Age _____	Birth Date _____		
D E P E N D E N T S	D1. Last Name _____ First Name _____ M.I. _____ Sex _____ Age _____ Birth Date _____					
	D2. Last Name _____ First Name _____ M.I. _____ Sex _____ Age _____ Birth Date _____					
	D3. Last Name _____ First Name _____ M.I. _____ Sex _____ Age _____ Birth Date _____					
	D4. Last Name _____ First Name _____ M.I. _____ Sex _____ Age _____ Birth Date _____					
	D5. Last Name _____ First Name _____ M.I. _____ Sex _____ Age _____ Birth Date _____					
	<i>For additional dependents, please attach a separate piece of paper, signed by the applicant, including the above information for each dependent.</i>					
A D D R E S S	3. Street Address _____					
	City _____		State _____	Zip Code _____		
	County _____		Township _____	Section _____		
	Telephone (Primary) _____			E-Mail Address _____		

B. COVERAGE SELECTION & PREMIUMS

<p>1. Benefit Plan — Primary:</p> <table style="width:100%; text-align:center;"> <tr> <td><input type="checkbox"/> A</td> <td><input type="checkbox"/> B</td> <td><input type="checkbox"/> C</td> <td><input type="checkbox"/> D</td> <td><input type="checkbox"/> E</td> </tr> <tr> <td>\$500</td> <td>\$1,000</td> <td>\$1,500</td> <td>\$2,000</td> <td>\$2,500</td> </tr> </table> <p align="center">(Includes Return of Premium Benefit Rider)</p> <p>2. Benefit Plan — Spouse:</p> <table style="width:100%; text-align:center;"> <tr> <td><input type="checkbox"/> A</td> <td><input type="checkbox"/> B</td> <td><input type="checkbox"/> C</td> <td><input type="checkbox"/> D</td> <td><input type="checkbox"/> E</td> </tr> <tr> <td>\$500</td> <td>\$1,000</td> <td>\$1,500</td> <td>\$2,000</td> <td>\$2,500</td> </tr> </table> <p>3. Benefit Plan — Dependents:</p> <table style="width:100%; text-align:center;"> <tr> <td><input type="checkbox"/> A</td> <td><input type="checkbox"/> B</td> <td><input type="checkbox"/> C</td> <td><input type="checkbox"/> D</td> <td><input type="checkbox"/> E</td> </tr> <tr> <td>\$500</td> <td>\$1,000</td> <td>\$1,500</td> <td>\$2,000</td> <td>\$2,500</td> </tr> </table>	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> E	\$500	\$1,000	\$1,500	\$2,000	\$2,500	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> E	\$500	\$1,000	\$1,500	\$2,000	\$2,500	<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> E	\$500	\$1,000	\$1,500	\$2,000	\$2,500	<p>4. Premium Payment Mode:</p> <p>Select One From Below: Select One From Below:</p> <table style="width:100%;"> <tr> <td><input type="checkbox"/> Bank Draft</td> <td><input type="checkbox"/> Monthly (N/A for Direct Billing)</td> </tr> <tr> <td><input type="checkbox"/> Credit Card</td> <td><input type="checkbox"/> Quarterly</td> </tr> <tr> <td><input type="checkbox"/> Direct Bill</td> <td><input type="checkbox"/> Semi Annual</td> </tr> <tr> <td><input type="checkbox"/> Payroll Deduction</td> <td><input type="checkbox"/> Annual</td> </tr> </table> <p>Draft/Bill Date: _____</p> <p>5. Modal Premiums:</p> <p>Primary: _____</p> <p>Spouse: _____</p> <p>Dependent: _____ x # _____ = _____</p> <p>Total: _____</p> <p>6. Beneficiary Designation</p> <p>Applicant: _____ Relationship _____</p> <p>Spouse: _____ Relationship _____</p>	<input type="checkbox"/> Bank Draft	<input type="checkbox"/> Monthly (N/A for Direct Billing)	<input type="checkbox"/> Credit Card	<input type="checkbox"/> Quarterly	<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Semi Annual	<input type="checkbox"/> Payroll Deduction	<input type="checkbox"/> Annual
<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> E																																			
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\$500	\$1,000	\$1,500	\$2,000	\$2,500																																			
<input type="checkbox"/> A	<input type="checkbox"/> B	<input type="checkbox"/> C	<input type="checkbox"/> D	<input type="checkbox"/> E																																			
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<input type="checkbox"/> Credit Card	<input type="checkbox"/> Quarterly																																						
<input type="checkbox"/> Direct Bill	<input type="checkbox"/> Semi Annual																																						
<input type="checkbox"/> Payroll Deduction	<input type="checkbox"/> Annual																																						

C. PRE-QUALIFICATION, MEDICAL INFORMATION & EXCLUSIONS

Has any person applying for coverage:

1. In the past 12 months been:
 - a. Confined to a hospital as an inpatient due to an accident related injury?
 - b. Disabled or received any disability payments?
 - c. Prescribed medication or had surgery, or recommended surgery, or undergone therapy for a back, neck or joint disorder?
2. In the past 5 years been treated for or diagnosed by a member of the medical profession as having:
 - a. Osteoporosis, Parkinson's disease, epilepsy or seizure disorder, paralysis, or fainting spells or blackouts?
 - b. Alzheimer's disease, multiple sclerosis, or alcohol or drug abuse?
3. In the past 3 years participated or intend to participate in flying as a private pilot or crew member, skydiving, parachuting, hang gliding, organized racing, mountain climbing, or bungee jumping?

APPLICANT'S ANSWER: Yes No (If yes, do not submit the application)

SPOUSE'S ANSWER: Yes No (If yes, the spouse does not qualify for this plan)

DEPENDENT 1 ANSWER: Yes No (If yes, dependent does not qualify for this plan)

DEPENDENT 2 ANSWER: Yes No (If yes, dependent does not qualify for this plan)

DEPENDENT 3 ANSWER: Yes No (If yes, dependent does not qualify for this plan)

DEPENDENT 4 ANSWER: Yes No (If yes, dependent does not qualify for this plan)

DEPENDENT 5 ANSWER: Yes No (If yes, dependent does not qualify for this plan)

Question #4 must be completed if the applicant (and spouse, if applying for coverage) are under age 65.

4. 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 12 months?

Applicant's answer Yes No (If "No", do not submit the application)

Occupation: _____

Spouse's answer Yes No (If "No", the spouse does not qualify for this plan)

Occupation: _____

D. COVERAGE INFORMATION

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.)

If "YES," with which company? _____
Policy Number: _____

Applicant	Spouse
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

E. AGENT'S STATEMENT

I certify that I have accurately recorded the information supplied by the Applicant(s). 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. (Section E is not required if agent is not present.)

Agent's Name (Printed)

Agent Code

Agent's Signature

Date

E-mail Address

MAIL POLICY TO: Agent Applicant

ACKNOWLEDGEMENTS & AUTHORIZATION

ALL STATEMENTS MADE IN THIS APPLICATION ARE FULL, COMPLETE AND TRUE, TO THE BEST OF MY KNOWLEDGE AND BELIEF. I UNDERSTAND THAT THE STATEMENTS FORM THE BASIS UPON WHICH INSURANCE WILL BE MADE EFFECTIVE. I UNDERSTAND THAT OMISSIONS, MISREPRESENTATIONS OR MISSTATEMENTS COULD RESULT IN DENIAL OF AN OTHERWISE VALID CLAIM AND/OR RESCISSION, VOIDING, OR REFORMATION OF INSURANCE.

I understand that any changes in my or my spouse's health conditions or that of my dependents (if applying for spouse and dependent coverage), from the date of this application until insurance becomes effective, may result in the declination of coverage. No agent or other representative of GTL has required, permitted, or encouraged me to answer any question inaccurately or has waived any conditions of this application. I have received a copy of the Pre-Notice which describes how information is obtained and used by GTL, and if applicable, the Guide to Health Insurance for people with Medicare and the outline of coverage. I understand that insurance applied for will not become effective until: (a) approved and issued by GTL; (b) I have been furnished written notice of the effective date; and (c) premiums have been paid in full.

AUTHORIZATION: I 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 physical condition, other coverage and any other information needed to underwrite my 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 the Company's 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 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 agree that this Authorization will be valid for 24 months from the date signed, and know that I or my authorized representative may have a photocopy of it.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending written notification to my agent or to the Company at the above address. I 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 agent or to the attention of the Underwriting Manager.

I 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 also understand that my application for insurance can be declined if I choose not to sign this Authorization.

Any person who knowingly and with intent to defraud an insurer files a statement of claim containing any false, incomplete or misleading information may be guilty of insurance fraud which is a crime.

If payroll deduction option has been selected, I hereby appoint and authorize my employer to deduct my insurance premium including administrative fees, if any, from my compensation and remit them to GTL. I acknowledge that no coverage will take effect until GTL has received at least one monthly premium payment, unless otherwise agreed upon.

Signed at _____
Date City and State

Applicant Signature

PLEASE DETACH AND GIVE TO PROPOSED INSURED

PRE-NOTICE TO PROPOSED INSURED

I understand that the insurance applied for shall not become effective until: a) approved and issued by GTL; and b) I have been furnished written notice of the effective date.

DO NOT CANCEL EXISTING COVERAGE UNTIL YOU RECEIVE WRITTEN NOTICE OF APPROVAL FROM GTL

In completing this application for insurance, it is understood that an investigative consumer report may be made whereby information is obtained through personal interviews with third parties such as family members; business associates; financial sources; friends; neighbors; or others with whom you are acquainted. This inquiry includes information as to your character; general reputation; personal characteristics; and mode of living, whichever may be applicable. You have the right to make written request within a reasonable time period for a disclosure of additional information concerning the nature and scope of the investigation. (See Disclosure Notice.)

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 thereon to the Medical Information Bureau, a not-for-profit membership organization of life 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, the Bureau, upon request, will supply such company with the information in its file. Upon receipt of a request form from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address to the Bureau's information office is P.O. Box 105, Essex Station, Boston, Massachusetts 02112, telephone number (617) 426-3660. 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.

NOTICE OF INFORMATION PRACTICES

GTL will need to obtain data about you and other persons proposed for insurance prior to issuing your coverage. Some data will be obtained from you and some from other sources. That data and any data that is collected at a later date, may in some cases be disclosed to third parties without your specific consent subject to the Company's privacy policies. You have the right of access and correction to data received about you. But, data about a claim or a civil or criminal proceeding is excepted. Details on these procedures will be furnished on request.

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

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 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 #: _____ 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 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 further 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

Credit Card Authorization
Not applicable if paying by check or money order

Name (on card) _____

Billing Address _____

Phone Number _____

Card Type Visa Master Card Discover

Card Number _____

Expiration Date _____

I authorize Guarantee Trust Life Insurance Company to bill my VISA / MASTERCARD/ DISCOVER for 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 _____

SERFF Tracking Number: *GRTT-125663666* *State:* *Arkansas*
Filing Company: *Guarantee Trust Life Insurance* *State Tracking Number:* *39162*
Company Tracking Number:
TOI: *H021 Individual Health - Accident Only* *Sub-TOI:* *H021.000 Health - Accident Only*
Product Name: *G0760 Accident Only*
Project Name/Number: *Platinum Accident Plan/*

Rate Information

Rate data does NOT apply to filing.

SERFF Tracking Number: GRTT-125663666 State: Arkansas
 Filing Company: Guarantee Trust Life Insurance State Tracking Number: 39162
 Company Tracking Number:
 TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
 Product Name: G0760 Accident Only
 Project Name/Number: Platinum Accident Plan/

Rate/Rule Schedule

Review Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed	G0760 Annual Premium Rate Sheet	G0760-AR	New		G0760 Rate Sheet.pdf
Approved-Closed	RG07ROP(D) Premium Factors	RG07ROP(D)	New		RG07ROP(D) filing rates.pdf
Approved-Closed	RG07ROP(T) Premium Factors	RG07ROP(T)	New		RG07ROP(T) filing rates.pdf

Rate Sheet

Guarantee Trust Life Insurance Company
Policy Form G0760, Rate Sheet

BASE PREMIUM RATE		<u>Plan A</u>	<u>Plan B</u>	<u>Plan C</u>	<u>Plan D</u>	<u>Plan E</u>
ADULT	under 65	220.00	365.00	560.00	660.00	810.00
	65-74	205.00	305.00	410.00	515.00	615.00
	75+	400.00	655.00	930.00	1,185.00	1,445.00
EACH DEPT CHILD		160.00	260.00	355.00	455.00	550.00

Annual policy fee 50.00 per policy

Note: disability benefit does not apply for ages 65 and above and for dependent children.

Modal Factors:

Annual	1.000
Semi-Annual	0.520
Quarterly	0.265
Monthly	0.090

Rate Factors

Guarantee Trust Life Insurance Company
Return of Premium Rider RG07ROP(D)
Premium Factors

Issue Age	Premium Factor *
18-64	20%
65-74	25%
75+	25%

* Applies to base and rider premiums only, not policy fee

Guarantee Trust Life Insurance Company
Return of Premium Rider RG07ROP(T)
Premium Factors

Return of Premium Period, Years	Premium Factor *		
	Age 18-64	Age 65-74	Age 75+
15	74%	74%	74%
16	63%	63%	63%
17	54%	54%	54%
18	47%	47%	47%
19	42%	42%	42%
20	39%	39%	39%

* Applies to base and rider premiums only, not policy fee

SERFF Tracking Number: GRTT-125663666 State: Arkansas
Filing Company: Guarantee Trust Life Insurance State Tracking Number: 39162
Company Tracking Number:
TOI: H021 Individual Health - Accident Only Sub-TOI: H021.000 Health - Accident Only
Product Name: G0760 Accident Only
Project Name/Number: Platinum Accident Plan/

Supporting Document Schedules

Satisfied -Name: Certification/Notice **Review Status:** Approved-Closed 07/07/2008
Comments:
Attachments:
AR_sub-Cert.pdf
READCERT.pdf
NOT-03-AR (Rev. 7-04).pdf

Satisfied -Name: Application **Review Status:** Approved-Closed 07/07/2008
Comments:
New Applications, APPH1-08 and APPH1-08(W) have been submitted and are shown under the Forms tab.

Satisfied -Name: Outline of Coverage **Review Status:** Approved-Closed 07/07/2008
Comments:
Attachment:
OCG0760-AR.pdf

Satisfied -Name: Statement of Variability **Review Status:** Approved-Closed 07/07/2008
Comments:
Attachment:
Statement of Variability.pdf

STATE OF ARKANSAS

CERTIFICATION OF COMPLIANCE

Re: Policy Form G0760-AR, et al

The Guarantee Trust Life Insurance Company of Glenview, Illinois does hereby certify that this policy form submission meets the provisions of Rule and Regulation 19 as well as all applicable requirements for this category of insurance pursuant to the Arkansas Department of Insurance.

GUARANTEE TRUST LIFE INSURANCE COMPANY

BY Allan J. Heindl

Allan J. Heindl, FLMI, HIA, AIRC
Vice President – Product Approval & Compliance

Date 5/30/2008

CERTIFICATE OF READABILITY

Form Number(s):

G0760-AR
RG07ROP(D)
RG07ROP(T)

Flesch Test Score(s):

41.5
45.3
45.9

I hereby certify that to the best of my knowledge and belief, the above form(s) meet the minimum reading ease requirements of your Department. The Flesch Reading Ease Test score(s) are listed above.

GUARANTEE TRUST LIFE INSURANCE COMPANY



Allan J. Heindl, FLMI, HIA, AIRC
Vice President – Product Approval & Compliance

Date: May 30, 2008

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, IL 60025
(847) 699-0600 or Toll-free 1-800-338-7452

Agent _____

Address _____

Telephone Number _____

IMPORTANT NOTICE

You may file a complaint with your state's Department of Insurance by writing:

Consumer Services Division
Arkansas Insurance Department
Room 120, First Floor
1200 West Third Street
Little Rock, AR 72201-1904

You may also contact the Consumer Services Division by telephone or fax at:

Telephone: (501) 371-2640
Toll-Free: 1-800-852-5494
Fax: (501) 371-2618

If you have Internet access, you may file an on-line complaint at the following email address:

Insurance.Consumers@mail.state.ar.us

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue
Glenview, Illinois 60025

ACCIDENT ONLY COVERAGE

OUTLINE OF COVERAGE

For Policy Form G0760-AR

[RG07ROP(D) – Return of Premium Benefit (Payable At Death Prior to Age 80)
RG07ROP(T) – Return of Premium Benefit (Payable Upon Completion of Specified Period)]

KEEP THIS OUTLINE OF COVERAGE FOR YOUR RECORDS

THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If you are eligible for Medicare, review the Guide to Health Insurance for People with Medicare available from the company.

READ YOUR POLICY CAREFULLY – This outline of coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

ACCIDENT ONLY COVERAGE – Policies of this category are designed to provide, to persons insured, coverage for certain losses resulting from a covered accident **ONLY**, subject to any limitations contained in the policy. Coverage is not provided for basic hospital, basic medical-surgical, or major medical expense.

BENEFITS

Policy benefit amounts are payable according to a Covered Person's selected Plan.

Benefit Description	Plan A	Plan B	Plan C	Plan D	Plan E
Hospital Confinement – For each day of hospital confinement Beginning with day 1 through day 90..... Beginning with the 91 st consecutive day through day 365.....	\$100/day \$200/day	\$200/day \$400/day	\$300/day 600/day	\$400/day \$800/day	\$500/day \$1,000/day
First Occurrence Confinement – If hospital confined within 24 hours of an Injury..... Limited to 1 payment per Accident, up to 2 payments per Calendar Year.	\$500	\$1,000	\$1,500	\$2,000	\$2,500
Ambulance – For transportation to the nearest hospital when due to an Injury. <u>Ground</u> – 1 transport per Accident, up to 4 ground transports per Calendar Year..... <u>Air</u> – 1 transport per Accident per Calendar Year..... One transport per Accident (either ground or air.) If both modes used, benefits will be paid at the air transport level.	\$250 \$1,000	\$250 \$1,000	\$250 \$1,000	\$250 \$1,000	\$250 \$1,000
Emergency Room For emergency treatment sought within 24-hours of an Accident at a Hospital or Hospital affiliated emergency care facility Limited to 1 payment per Accident, up to 4 Emergency Room payments per Calendar Year	\$100	\$200	\$300	\$400	\$500
Emergency Medical, Dental or Chiropractic Treatment – Benefit payable per visit if treatment is received as a result of Injury..... Limited to a combined total of 6 visits per Calendar Year for all medical, dental and chiropractic treatments.	\$25/visit	\$25/visit	\$25/visit	\$25/visit	\$25/visit
Outpatient Therapy – Benefit payable per visit..... Limited to a combined total of 6 visits for all covered therapies per Accident.	\$50	\$50	\$100	\$100	\$100
Surgical Procedures – Benefit payable per Accident	\$250	\$500	\$750	\$1,000	\$1,250

Benefit Description	Plan A	Plan B	Plan C	Plan D	Plan E
Fracture – Benefit payable per Accident, up to 4 Fracture payments per Calendar Year Benefits vary by severity of Fracture	Up to, \$2,500	Up to, \$5,000	Up to, \$7,500	Up to, \$10,000	Up to, \$12,500
Prosthesis – Benefit payable per Accident...	\$2,000	\$4,000	\$6,000	\$8,000	\$10,000
Accidental Death					
Primary Insured	\$15,000	\$30,000	\$45,000	\$60,000	\$75,000
Spouse (if covered under the policy).....	\$15,000	\$30,000	\$45,000	\$60,000	\$75,000
Dependent Child (if covered under the policy)	\$ 2,000	\$ 4,000	\$ 6,000	\$ 8,000	\$10,000
Accidental Dismemberment					
Loss of both hands, both feet or sight in both eyes..	\$10,000	\$20,000	\$30,000	\$40,000	\$50,000
Loss of one hand, one foot or sight in one eye....	\$ 5,000	\$10,000	\$15,000	\$20,000	\$25,000
Loss of one or more fingers and/or toes.....	\$ 500	\$ 1,000	\$ 1,500	\$ 2,000	\$ 2,500
Maximum payout for all dismemberment loss per Accident.....	\$20,000	\$40,000	\$60,000	\$80,000	\$100,000
Disability Income* (Primary Insured and spouse, if covered under the policy)					
Monthly Disability Income Benefit.....	\$500	\$1,000	\$2,000	\$2,000	\$2,500
Maximum Disability Income Benefit.....	Up to, 12 mos.				
Disability Income Benefit Period Per Period of Disability.....	Up to, 6 mos.				
Elimination Period Per Period of Disability.....	90 consecutive days				

*For the purpose of benefit payment under the policy, Disability means a person: (1) is unable, due to Injury, to do the Substantial and Material Duties of his or her regular occupation for wage or profit; (2) is receiving regular care by a Doctor appropriate for the injury causing the Disability; and (3) not doing any other work for wage or profit.

After the Maximum Disability Income Benefits have been paid, benefits will be fully restored after 48 consecutive months from the date of the last Monthly Disability Income Benefit payment. Any new Disability incurred must be as a result of a new Injury.

The Disability Income benefit will end, and premiums will be reduced accordingly, on the policy anniversary following a Covered Person's 65th birthday. However, any Disability that begins prior to a person's 65th birthday will continue, up to any benefit payments remaining in the Disability Income Benefit Period.

EXCLUSIONS

The policy does not pay benefits for:

- Treatment, services or supplies which:
 - Are not Medically Necessary;
 - Are not prescribed by a Doctor as necessary to treat an Injury;
 - Are determined to be Experimental/Investigational in nature;
 - Are received without charge or legal obligation to pay;
- Intentionally self-inflicted Injury, violating or attempting to violate any duly enacted law.
- Injury by acts of war, whether declared or not.
- Injury received while traveling or flying by air, except as a fare-paying passenger on a regularly scheduled commercial airline.
- Dental treatment, except as specifically stated.
- Treatment of Sickness, disease or infections, except pyogenic infections or bacterial infections which result from the accidental ingestion of contaminated substances.
- Suicide or attempted suicide while sane; or self-destruction or an attempt to self-destroy while insane.
- Injury sustained while committing or attempting to commit a felony.
- Injury sustained while voluntarily participating in a riot or civil commotion or disturbance of any kind.
- Loss occurring while the Covered Person is incarcerated if the incarceration is during a period of legal incarceration in a penal or correctional institution of more than seven (7) days or during a period of legal detainment of more than seven (7) days.
- Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay.
- 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.
- Loss resulting from an Accident where the Covered Person is the operator of a motor vehicle and did not possess a current and valid driver's license to operate that class of vehicle at the time of the Accident.
- Loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a Doctor.
- Injury which occurs while a Covered Person is on active duty service in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond thirty-one (31) days.
- Cosmetic surgery, except for reconstructive surgery on an injured part of the body.

- Loss resulting from competing in motor sport or water sport races or competitions.
- Loss resulting from testing cars/trucks on any racetrack or speedway.
- Loss resulting from handling, storing or transporting explosives.
- Loss resulting from spelunking (exploring caves); or scaling up or down cliffs or mountain walls.
- Loss resulting from practice for or participation in a rodeo.
- Injury sustained flying in an ultra light, hang gliding, parachuting, bungee cord jumping.
- Injuries incurred outside of the United States or its possessions, unless such loss is incurred while the Covered Person is on a trip of not more than 60 days.

[**RETURN OF PREMIUM OPTIONS** (*Additional premium required*)

[Return of Premium Upon Death Benefit Rider RG07ROP(D): In the event of your death before your 80th birthday, a return of premium benefit will be paid to your named beneficiary or estate. The actual amount of premium to be returned, if any, will be equal to:

1. The sum of all premiums you paid for the policy, including premiums paid for the Return of Premium rider. Any application and annual policy fees are not included in the refund. Premium also includes premiums paid for any dependent(s). The sum of all premiums is without interest accumulation. MINUS
2. The sum of all benefits paid or then payable under the policy to you or on your behalf while this Return of Premium rider was in force.]

[Return of Premium Benefit Rider RG07ROP(T) (*Payable Upon Completion of Specified Return of Premium Period*): This rider may provide a return of premium benefit in the event your policy remains in force for [15] [16] [17] [18] [19] [20] full years. The actual amount of premium that will be returned, if any, will be equal to:

1. For issue ages 59 and under: 100% of all premiums you paid for the policy.
For issue ages 60 and above: 80% of all premiums you paid for the policy.
Premium paid for the policy includes premiums paid for this rider. Any application and annual policy fees are not included in the refund. Premium also includes premiums paid for any dependent(s) insured under the policy. The sum of all premiums is without interest accumulation.
2. From the sum of all premiums paid in #1, above, we will subtract all benefits paid or then payable under the policy for you or any dependent(s).

At the end of the Return of Premium Period, you will have the option of renewing this rider . Renewal is conditioned upon the new Return of Premium Period beginning before your attained age 76. If renewed, the renewal premium will be based on your attained age at the start of the new Return of Premium Period.]

RENEWABILITY - THIS POLICY IS GUARANTEED RENEWABLE. This means you have the right, subject to the terms of your policy, to continue the policy as long as you pay your premiums on time. We cannot change any of the terms of your policy on our own, except that, in the future, WE MAY INCREASE THE PREMIUM YOU PAY. A change in premium may be due to an increase in age, a change in benefits, or a new table of rates. We will provide you with written notice at least 31 days in advance of any change in renewal premium.

	Initial Annual Premium	Primary Insured	Spouse, (if applying for coverage)	Dependent Child(ren) (if applying for coverage.) Cost is per child.
		Plan	Plan	Plan
1	Accident Only Policy	\$ _____	\$ _____	\$ _____ x _____ child(ren)
2	[Return of Premium (Death before age 80)	\$ _____]		
3	[Return of Premium (Payable at end of specified term)	\$ _____]		
4	Annual Policy Fee	\$50.00		
5	Annual Premium Sub-Total	\$ _____	\$ _____	\$ _____ (total for all children)

(Add sub-totals from line 5, across) **TOTAL ANNUAL POLICY PREMIUM: \$ _____**

Agent Name: _____ Agent Address: _____

Telephone Number: _____

Filing note: Bracketed text is indicated for those benefit summaries/premium information lines which are being filed as variable. These benefits are not currently mandated to be offered and the Company reserves the right to discontinue marketing these riders in the future.

Guarantee Trust Life Insurance Company

Statement of Variability For G0760-AR (Policy) APPH1-08 and APPH1-08(W) (Applications)

The bracketing of variable text in Policy form G0760 is limited to the following:

1. PAGE 1 of the Policy – Variability is limited to the Policy Owner Name, Policy Effective Date , Policy Number, and signature of current President and Secretary of Guarantee Trust Life Insurance Company

Policy Schedule

2. Policy Number: Automatically assigned at the time policy is issued by the Company.
3. Effective Date: Date policy becomes effective – either of: (a) the date the application is signed or the date the applicant(s) are determined to have completed the company’s underwriting process; or (b) the effective date requested by the applicant.
4. Name of Insured: Applicants name.
5. Age at Issue: Applicant’s attained age
6. State of Issue: The state the Policy is issued in.
7. Mode Selected: Premium payment schedule selected by the Applicant. Limited to: Monthly, Quarterly, Semi-Annually or Annually
8. Benefit Plan: Limited to Plans A, B, C, D, and E (*with benefit amounts increasing upward from Plan A*)
9. Covered Dependents: This section will show if additional family members are covered, such as spouse and children. The names, age(s) at issue and the benefit plan chosen will also reflect in this section.
10. Annual Premiums: The annual premium for each insured member for the Accident Only Coverage is shown. Also, the Return of Premium annual premium will be shown. The Return of Premium Period (from 15 through 20 year choices) will be shown, if the Return of Premium Benefit Rider is for a specified period.
11. Annual Policy Fee: \$50.00
12. Total Premiums: Varies by number and age of the insured and covered dependents, as well as choice of benefit plan(s).

Applications APPH1-08 and APPH1-08(W)

13. Section B – Benefit Plans A through E will be offered. In the event additional plans (for example a higher hospital benefit or disability income benefit) the rates and schedule pages for such plans will be filed for approval. However, we would not anticipate refiling the applications for this change. Instead our cover letter would indicate the application in use and that such application would be modified in the Coverage Selection are only.

Variability is limited to changing these portions only in context that remains compliant with Arkansas regulatory requirements. Any new benefit plans, benefit periods, or premium rates will be filed with the Arkansas Department of Insurance before use. The Company reserves the right to discontinue marketing benefit riders not mandated under state law.



Theresa A. Tyc, Product Approval and Compliance
Guarantee Trust Life Insurance Company
May 30, 2008

SERFF Tracking Number: *GRTT-125663666* State: *Arkansas*
 Filing Company: *Guarantee Trust Life Insurance* State Tracking Number: *39162*
 Company Tracking Number:
 TOI: *H021 Individual Health - Accident Only* Sub-TOI: *H021.000 Health - Accident Only*
 Product Name: *G0760 Accident Only*
 Project Name/Number: *Platinum Accident Plan/*

Superseded Attachments

Please note that all items on the following pages are items, which have been replaced by a newer version. The newest version is located with the appropriate schedule on previous pages. These items are in date order with most recent first.

Original Date:	Schedule	Document Name	Replaced Date	Attach Document
No original date	Form	Accident Only Policy	06/01/2008	G0760-AR.pdf

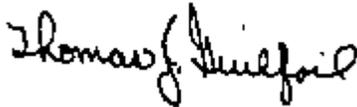
**GUARANTEE TRUST LIFE
INSURANCE COMPANY**
A Mutual Company
1275 Milwaukee Avenue
Glenview, Illinois 60025
(847) 699-0600

**ACCIDENT ONLY
POLICY**

Includes Limited Benefits for
Disability Income

**THIS IS A LEGAL
CONTRACT BETWEEN
YOU AND US. READ YOUR
POLICY CAREFULLY.**

Signed for Guarantee Trust Life
Insurance Company, at its Home
Office, by:



Secretary



President

WE PROMISE to insure You for the benefits described in this Policy. Benefits are subject to the Policy definitions, provisions, limitations and exclusions. This Policy is issued in consideration of the application and payment of the first Premium. The application is attached to and made a part of this Policy.

Licensed Resident
Agent

GUARANTEED RENEWABLE. You may keep this Policy in force during Your entire lifetime by paying the renewal premium at the intervals available to You at the time of renewal. You must pay the premium when due or within the grace period. We cannot cancel or refuse to renew this Policy or place any restrictions on it if You pay Your Premiums on time.

YOUR RIGHT TO EXAMINE THIS POLICY FOR TEN (10) DAYS. It is important to us that you are satisfied with this Policy. If You are not satisfied with this Policy, You may return it to us within ten (10) days of its receipt. Upon Our receipt of Your returned Policy, We will cancel the Policy as of the Effective Date and refund any premiums You have paid.

PREMIUMS ARE SUBJECT TO CHANGE. The premium rates for this policy may change, but only if they are changed for all policies like Yours on a class basis. The change may be due to an increase in age, a change in benefits, or a new table of rates. We will provide You with written notice at least thirty-one (31) days in advance of any change in renewal premium.

IMPORTANT NOTICE

Please read the copy of the application attached to this Policy. Carefully check the application and write to Us at the address shown above within ten (10) days if any information shown on it is not correct and complete. If Your answers are incorrect or untrue, We may have the right to deny benefits or rescind Your policy. The application is a part of this Policy and this Policy was issued on the basis that the answers to all questions and the information shown on the application are correct and complete.

If You have any problems, complaints or questions concerning this Policy, please write Us at the above address or call us at 800 338-7452. If We are unable to satisfy You, You may write the Arkansas Consumer Services Division, Department of Insurance, 1200 W. Third Street, Little Rock, AR 72201-1904 or call 800 282-9124.

**THIS IS AN ACCIDENT ONLY POLICY.
IT DOES NOT PAY BENEFITS FOR LOSS AS A RESULT OF SICKNESS.**

**THIS IS NOT A MEDICARE SUPPLEMENT POLICY. If You are eligible for Medicare,
review the Medicare Supplement Buyer's Guide available from the Company.**

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Benefit and Fracture Schedule(s) Attached

CONSIDERATION

We have issued this policy in consideration of the statements made in the application and payment of the First Premium. The application is attached and made a part of this policy.

POLICY DEFINITIONS

Accident: A sudden, unforeseeable, external event that results in an Injury.

Actively At Work (Active Work): Means a Covered Person is performing the Substantial and Material Duties of his or her Regular Occupation at the normal place of business for thirty (30) or more hours per week.

Ambulance: A vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation to a Hospital or transportation from one Hospital to another for those individuals who are unable to travel to receive medical care by any other means. Air ambulance charges are only eligible for transportation from the site of an Emergency to the nearest appropriate facility.

Ambulatory Surgical Center: A facility that is accredited by a national accrediting body or licensed by a state agency and which:

- Is equipped and operated to provide medical care and treatment by a Doctor;
- Does not provide services or accommodations for overnight stays;
- Has a full time medical staff that is under the supervision of a duly licensed Doctor;
- Has at least one licensed registered nurse (R.N.) on duty at all times when patients are in the facility;
- Has at least one operating room and one recovery room and is equipped to support any surgery performed;
- Has X-ray and laboratory diagnostic facilities;
- Maintains a medical record for each patient; and
- Has a written agreement with at least one Hospital for the immediate transfer of patients who develop complications or need confinement.

Calendar Year: The period beginning on the date a Covered Person's coverage becomes effective and ending on December 31 of that same year. Form then on, it is the period beginning January 1 and ending on December 31 of that same year.

Chiropractic Treatment: A Medically Necessary treatment or procedure performed by a Doctor of chiropractic.

Common Carrier: Any scheduled airline, land, or water conveyance licensed for the transportation of passengers for hire. Common Carrier does not include a conveyance operated for sport, recreation, and/or sightseeing activities or for any travel in any aircraft device for aerial navigation except as expressly provided in the policy.

Covered Person: Means You or a person:

1. who is eligible for coverage as Your Dependent
2. who has been accepted for coverage or has been automatically added.
3. who has paid the required premium; and
4. whose coverage has become effective and has not terminated.

Covered Person, for purposes of the Monthly Disability Income Benefit is limited to You and Your Dependent spouse, if also insured under this Policy.

Daily Benefit Amount: The amount We will pay each day when Hospital Confined due to Injury. The Daily Benefit Amount is shown in the Benefits Schedule.

Dental Treatment: A Medically Necessary treatment or procedure performed in the oral cavity.

Policy Definitions (Continued)

Dependent: A person who is Your:

1. legally married spouse (or state recognized common law spouse), residing with You.
2. child who is dependent upon You for support and maintenance and is under the age of nineteen (19).
3. child who is dependent upon You for support and maintenance, is nineteen (19) through twenty-five (25) years of age and is attending school full time, as determined by the school the Dependent is attending, including colleges and vocational, technical, vocational-technical or trade schools or institutes.

The term child refers to Your and Your spouse's unmarried:

1. natural child;
2. stepchild; a stepchild is a Dependent on the date You marry the child's parent; and
3. adopted child, including a child placed with You for the purpose of adoption, from the moment of placement as certified by the agency making the placement.

Disability / Disabled: Means a Covered Person who:

- is unable, due to an Injury, to do the Substantial and Material Duties of his or her Regular Occupation for Wage or Profit as such existed at the start of any Disability for which a claim for benefits is made under this Policy;
- is receiving regular care by a Doctor that is appropriate for the Injury causing the Disability. This care must be at such intervals as will lead to his or her return to work. The Covered Person need not be under a Doctor's care on a regular basis if he or she can show that further recovery is not expected; and
- is not doing any other work for Wage or Profit.

Disability Income Benefit Period: The maximum number of months the Monthly Disability Income Benefit will be paid for a Period of Disability. The Disability Income Benefit Period is shown in the Benefits Schedule.

Doctor: A legally qualified person licensed in the healing arts and practicing within the scope of his or her license. A Doctor does not include You or a Family Member.

Elimination Period: The number of consecutive days after a Disability starts during which the Monthly Disability Income Benefit is not paid. The Elimination Period must be satisfied for each Period of Disability incurred. The Elimination Period is shown in the Benefits Schedule.

Emergency: An Injury for which a Covered Person seeks immediate medical treatment at the nearest available Hospital. The condition must be one which manifests itself by acute symptoms which are sufficiently severe (including severe pain) that without immediate medical care the Covered Person could reasonably expect that: (1) his or her life or health would be in serious jeopardy; (2) his or her bodily functions would be seriously impaired; or (3) a body organ or part would be seriously damaged.

Experimental/Investigational: A drug, device or medical care or treatment will be considered experimental/investigational if:

- the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug is administered or the device is furnished;
- the informed consent document utilized with the drug, device, medical care or treatment states or indicates that the drug, device, medical care or treatment is part of a clinical trial, experimental phase or investigational phase or if such a consent document is required by law;
- the drug, device, medical care or treatment or the patient informed consent document utilized with the drug, device or medical care or treatment was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal or state law requires such review and approval;
- reliable evidence show that the drug, device or medical care or treatment is the subject of ongoing Phase I or Phase II clinical trials, is the research, experimental study or investigational arm of on-going Phase III clinical trials, or is otherwise under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis; or
- reliable evidence show that the prevailing opinion among experts regarding the drug, device or medical care or treatment is that further studies or clinical trials are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment of diagnosis.

Reliable evidence means only: published reports and articles in authoritative medical and scientific literature; written protocol or protocols by the treating facility studying substantially the same drug, device or medical care or treatment; or the written informed consent used by the treating facility or other facility studying substantially the same drug, device or medical care or treatment. Charges will be considered in accordance with the drug, device or medical care at the time the expense is incurred.

Policy Definitions (Continued)

Family Member: A person, including You, who is related to a Covered Person in any of the following ways: spouse (includes state recognized common-law), brother-in-law, sister-in-law, son-in-law, daughter-in-law, father-in-law, mother-in-law, parent (includes stepparent), brother or sister (includes stepbrother or stepsister), or child (includes legally adopted, step or foster child.)

Hospital: An institution licensed, accredited, or certified by the State which:

- is accredited by the Joint Commission on Accreditation of Healthcare Organizations;
- provides 24-hour nursing service by registered nurses (R.N.);
- mainly provides diagnostic and therapeutic care under the supervision of Doctors on an inpatient basis; and
- maintains permanent surgical facilities or has an arrangement with another surgical facility supervised by a staff of one or more Doctors.

Hospital also includes tax-supported institutions, which are not required to maintain surgical facilities.

Hospital does not include a place, special ward, floor, or other accommodation used for: custodial, educational care, or rehabilitation; rest; the aged; a nursing home or an institution mainly rendering treatment or services for mental or nervous disorders or substance abuse.

Hospital Confined/Hospital Confinement: Confinement in a Hospital for at least 24 consecutive hours by reason of an Injury for which benefits are payable and there is a charge for room and board.

Injury / Injuries: Bodily injury due to an Accident which:

- results directly and independently of disease, bodily infirmity or any other causes;
- solely, directly and independently of all other causes results in medical expense;
- occurs after the effective date of the Covered Person's coverage under this Policy; and
- occurs while this Policy is in force.

All Injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these Injuries, are considered a single Injury.

Maximum Disability Income Benefit: The maximum number of Monthly Disability Income Benefit payments payable for all combined Periods of Disability per Covered Person. The Maximum Disability Income Benefit is shown in the Benefit Schedule.

Medically Necessary: A treatment, drug, device, procedure, supply or service that is necessary and appropriate for the diagnosis or treatment of an Injury in accordance with generally accepted standards of medical practice in the United States at the time it is provided. When specifically applied to Hospital confinement, it means that the diagnosis or treatment of symptoms or a condition cannot be safely provided on an outpatient basis.

A treatment, drug, device, procedure, supply, or service shall not be considered as Medically Necessary if it:

- is Experimental/Investigational or for research purposes;
- is provided solely for education purposes or the convenience of the Covered Person, the Covered Person's family, Doctor, Hospital or any other provider;
- exceeds in scope, duration, or intensity that level of care that is needed to provide safe, adequate and appropriate diagnosis or treatment and where ongoing treatment is merely for maintenance or preventive care;
- could have been omitted without adversely affecting the person's condition or the quality of medical care;
- involves the use of a medical device, drug or substance not formally approved by the United States Food and Drug Administration;
- involves a service, supply or drug not considered reasonable and necessary by the Healthcare Financing Administration Medicare Coverage Issues Manual; or
- can be safely provided to the patient on a less cost-effective basis such as outpatient, by a different medical professional, or pursuant to a more conservative form of treatment.

We reserve the right to determine whether a service, supply, or drug is Medically Necessary.

Policy Definitions (Continued)

Medical Treatment: Medically Necessary treatment or procedure provided to a Covered Person by a Doctor and which is received solely as a result of an Injury.

Mental or Nervous Disorder: Any condition or disease, regardless of its cause, listed in the most recent edition of the *International Classification of Diseases* as a Mental Disorder on the date the medical care or treatment is rendered to the Covered Person.

Monthly Disability Income Benefit: The amount payable, after the Elimination Period is satisfied, for each month the Covered Person is Disabled. The Monthly Disability Income Benefit amount is shown in the Benefit Schedule.

Outpatient Facility: A facility which

- Meets licensing and other legal requirements and is equipped to provide surgical services;
- Classified by the Hospital as an out-patient facility; and
- In which you are confined for less than 24 hours.

Period of Disability: A period of disability begins on the date of the first treatment by a Doctor for the Disability. It ends upon a return to Active Work for a period of not less than 90 days.

Prosthesis: An artificial substitute or replacement of an external body part. Covered prosthesis includes, but is not limited to: arm, leg, hip, knee, eye, or ear. It does not include dental prosthetics.

Recurrent Disability: A Disability will be considered a recurrence of a prior Disability if it is due to the same or related causes as the prior Disability and is separated from the prior Disability by less than 90 days of return to Active Work. Such Recurrent Disability will be subject to the Policy's provisions that were in effect at the time the prior Disability began.

Disability that begins more than 90 days after the end of a prior Disability shall be subject to:

- A new Elimination Period;
- Any Maximum Disability Income Benefit remaining; and
- The other provisions of the Policy that are in effect on the date Disability recurs.

Regular Occupation: The occupation(s) that a Covered Person is performing for Wage or Profit on the date he or she becomes Disabled.

Sickness means illness or disease which manifests itself while this Policy is in force. Complications of pregnancy will be considered a sickness.

Sound Natural Teeth: Natural teeth, the major portion of the individual tooth which is present, regardless of fillings and caps; and is not carious, abscessed, or defective.

Substantial and Material Duties: The necessary functions of a Covered Person's Regular Occupation which cannot be altered or reasonably omitted.

Wage or Profit: Salaries, bonuses, commissions, fees, and other income amounts received as payment for personal services rendered or work performed and based on an average forty (40) hour workweek. Wage or Profit also includes any contribution made by a Covered Person or on his or her behalf to any pension, profit sharing, or deferred compensation plan, unless such contributions are waived during a Period of Disability. Wage or Profit does not include dividends, rents, royalties, annuities, or other forms of unearned income. Proof of current Wage may be required when filing a claim under Part K of this policy.

We, Us, Our and Company: Guarantee Trust Life Insurance Company.

You, Your and Yours: The person named as the Insured in the Policy Schedule.

ELIGIBILITY AND ADDITIONS

Section A – General Eligibility

A person who makes application for coverage under the Policy will become an Insured person if he or she meets our underwriting standards for coverage.

If You are eligible to apply for coverage under the Policy, You may apply to include as Covered Persons:

1. Your lawful spouse (or state recognized common law spouse);
2. each unmarried child of Yours who is a Dependent.

Section B – Dependents Acquired After Effective Date

Newborn Child: Your newborn child is automatically covered from the moment of birth until such child is thirty-one (31) days old. Coverage for such child will be for Injury. However, You must notify Us in writing within thirty-one (31) days of such birth and pay the required additional premium, if any, in order to have coverage for the newborn child continue beyond such thirty-one (31) day period.

Adopted Child: Coverage for an adopted child shall begin on the date of the filing of a petition for adoption. If You apply for coverage within sixty (60) days after the filing of the petition for adoption. However, coverage shall begin from the moment of birth if the petition for adoption and application for coverage is filed within sixty (60) days after the birth of the minor.

Other Than Newborn or Adopted Child: A person who qualifies as a Dependent after the Effective Date of coverage may be insured under this Policy. Application and premium must be received by Us within thirty-one (31) days after the date the person first qualifies as a Dependent, and the required premium must be paid. Coverage is effective upon receipt of an application for coverage, our underwriting standards are met and premium is paid.

If You do not meet the applicable requirements, a child as set forth in this section will cease to be a Covered Person at the end of the thirty-one (31) day period.

Section C – Termination

A child will cease to be covered on the premium due date that follows the earlier of such child's: (a) nineteenth (19th) birthday, twenty-fifth (25th) birthday if a full-time student; or (b) date of marriage.

The coverage of a child will not terminate if that child is both: (a) incapable of self-sustaining employment because of mental retardation or physical handicap; and (b) currently dependent upon You. Proof of continued incapacity and dependency must be furnished to Us by You within thirty-one (31) days of the child's nineteenth (19th) birthday. Afterwards, proof of continued incapacity and dependency must be furnished to Us, at Our request, by You but not more frequently than annually after the two-year period following the child's nineteenth (19th) birthday, unless such information is requested as a part of Our claim processing.

Coverage of Your spouse shall cease on the premium due date that follows the date of entry of a valid judgment of dissolution of marriage.

Section D – Continuation of Coverage

If You die, Your spouse, if any and covered under this Policy, will become the Insured and have the right to continue coverage for all Covered Persons under this Policy. A written request for continuation of coverage for all Covered Persons and the appropriate premium must be received by Us within thirty-one (31) days after Your death. Upon Our receipt of such written request and premium, We will issue a new policy. The new policy will be issued based on the attained age(s) of the Insured and any remaining dependent children.

We will terminate this Policy if the written request for continuation and the appropriate premium is not received by Us within thirty-one (31) days after Your death.

ELIGIBILITY AND ADDITIONS (Continued)

Section E – Conversion Option:

A covered Dependent may apply for a Conversion policy if coverage under this Policy terminates, except for non-payment of premium, as set forth in the Termination provision. The Conversion Policy will be issued without proof of good health, subject to the following conditions: a written application for the Conversion policy is sent to Us within thirty-one (31) days of the date on which such person's coverage under this Policy ends. The Effective Date of the Conversion policy shall be the date such person's coverage ended under this Policy. The premium for the Conversion policy will be based on: (1) the attained age of the covered Dependent; and (2) the premium rate table currently in effect for the Conversion policy form and amount of coverage provided.

1. The Conversion policy will be this or a similar form currently in use by Us.
2. the Conversion policy may exclude any condition excluded by this Policy with respect to the covered Dependent at the time of the termination of coverage under this Policy. We will not pay benefits under the Conversion policy for expenses incurred while this Policy is in force.
3. any benefit amounts paid for a covered Dependent under this Policy will be applied to any benefit limits under the converted policy.

Termination of coverage because a person ceases to be a Covered Person is without prejudice to any claim originating prior to termination of coverage.

BENEFIT PROVISIONS

Please refer to the Benefits Schedule Page for the benefit amounts payable and limits for each of the benefits listed below. Unless specified otherwise, benefit limits shown below are per Covered Person.

A. DAILY HOSPITAL CONFINEMENT BENEFIT

We will pay the Daily Benefit Amount for ninety (90) days for each day a Covered Person is Hospital Confined when such confinement is Medically Necessary as a result of an Injury.

The Daily Benefit Amount will double if the Hospital Confinement continues on and beyond the ninety-first (91st) day from the initial Hospital Confinement for the same Accident.

The Daily Benefit Amount is payable for up to three-hundred sixty five (365) days of Hospital Confinement per Accident.

B. AMBULANCE SERVICE BENEFIT

We will pay the Ambulance Service Benefit for air or ground Ambulance service when needed to transport a Covered Person to the nearest available Hospital due to an Injury. The Ambulance Service Benefit is limited to:

- (1) One (1) transport per Accident for ground transport service, not to exceed payment for four (4) ground Ambulance transports per Calendar Year;
- (2) One (1) transport per Accident for air transport services per Calendar Year.
- (3) One transport per Accident (either ground or air.) If both modes of transport are used for one Accident, benefits will be payable at the air transport services benefit level.

C. EMERGENCY ROOM BENEFIT

We will pay for services rendered to a Covered Person in a Hospital emergency room or Hospital affiliated emergency care facility for loss sustained as a result of an Injury. Emergency treatment must be sought within twenty-four (24) hours of the Accident. The Emergency Room Benefit is limited to one (1) Emergency Room treatment per Accident, not to exceed four (4) Emergency Room treatments per Calendar Year.

D. EMERGENCY MEDICAL, DENTAL OR CHIROPRACTIC TREATMENT BENEFIT

We will pay for Emergency Medical, Dental, or Chiropractic treatments a Covered Person receives as result of an Injury. Payment is limited to a combined total of six (6) visits per Calendar Year for any and all Medical, Dental, or Chiropractic Treatments received.

BENEFIT PROVISIONS (Continued)

E. OUTPATIENT THERAPY

We will pay the Outpatient Therapy benefit for outpatient therapies a Covered Person receives as a result of an Injury. Covered therapies are limited to physical, speech, hearing and occupational. Payment for this benefit is limited to a combined total of six (6) visits for all forms of therapy per Accident.

F. FIRST OCCURRENCE CONFINEMENT

We will pay the First Occurrence benefit in the event a Covered Person is Hospital Confined within twenty-four (24) hours of sustaining an Injury. The First Occurrence benefit is limited to one (1) payment per Accident, not to exceed two (2) payments under this benefit provision per Calendar Year.

G. PROSTHESIS BENEFIT

We will pay the Prosthesis benefit when a Covered Person receives a prosthesis or prosthetic device as a direct result of an Injury. The Prosthetics benefit is limited to one (1) payment per Accident. This benefit does not cover replacement of any existing prosthesis.

H. FRACTURE BENEFIT

We will pay the Fracture benefit, as shown in the Fractures Schedule, when a Covered Person receives services that are deemed to be Medically Necessary for the treatment of a fracture sustained as a direct result of an Injury. A fracture for the purposes of coverage under this policy refers to a break in bone or cartilage which is the result of trauma. It does not include a fracture caused by an acquired disease, such as osteoporosis or Padgett's disease or by abnormal formation of bone in a disease such as osteogenesis imperfecta. The Fracture benefit is limited to one (1) payment per Accident, not to exceed four (4) payments under this benefit provision per Calendar Year.

I. OUTPATIENT SURGICAL BENEFIT

We will pay the Outpatient Surgical Benefit for a surgical procedure performed by a Doctor when such procedure is performed in a Hospital, Ambulatory Surgical Center or Outpatient Facility of a Hospital. The surgery must be deemed Medically Necessary and performed as a result of a sustained Injury. The Surgery benefit is limited to one (1) payment per Accident without regard to the number of surgical procedures rendered.

J. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

We will pay the Accidental Death Benefit to the beneficiary named in the application (or as later changed) if a Covered Person should die solely as a result of Injuries. Accidental death must occur while this Policy is in force for the Covered Person and within ninety (90) days after the Accident causing the Injuries.

We will pay the appropriate Accidental Dismemberment Benefit if a Covered Person suffers total and irrecoverable loss of eyesight or limbs solely as the result of an Injury. The dismemberment must occur while this Policy is in force for the Covered Person and within ninety (90) days after the Accident causing the Injuries.

Loss means with regard to hands and feet, dismemberment by severance through or above the wrist or ankle joint; with regard to eyes, the loss of sight must be total and irrecoverable, and beyond remedy by surgical or other means.

For all loss (dismemberment and/or death) sustained as a result of one Accident, We will pay the greater of the benefit amount for loss due to dismemberment or for loss due to death or balance thereof if dismemberment benefits have been previously paid.

K. DISABILITY INCOME BENEFIT

This benefit is limited to You and Your Dependent spouse, if insured under this Policy.

We will pay the Monthly Disability Income Benefit for Disability due to an Injury. Benefit payment is subject to the satisfaction of the Elimination Period. Disability must start within thirty (30) days after the Accident causing the Injury. The Injury must occur while coverage under the policy is in force for the Covered Person.

The Disability Income Benefit is limited to:

- (1) The Monthly Disability Income Benefit amount;
- (2) The Disability Income Benefit Period per Period of Disability, inclusive of Recurrent Disability; and
- (3) The Maximum Disability Income Benefit for all combined Periods of Disability.

BENEFIT PROVISIONS (Continued)

Disability Income Benefit: (Continued)

After the Maximum Disability Income Benefit payments have been made for a Covered Person, any future payment of benefits under this provision will remain subject to the Restoration of Benefits provision.

If Disability is caused by more than one Injury, We will pay benefits as if it was caused by only one injury. We will not pay more than the Disability Income Benefit Period for any one Period of Disability.

Disability starts on the date of the first treatment by a Doctor for the Disability. Disability is considered to continue, and the Monthly Disability Income Benefit will be paid, only while the Covered Person is under the care of a Doctor for the cause of the Disability. The Doctor must state in writing that the Covered Person continues to be Disabled.

The Disability Income Benefit under this policy ends and a corresponding reduction in premium will be made for each applicable Covered Person upon the first policy anniversary which follows his or her sixty-fifth (65th) birthday. However, any Disability that begins prior to a Covered Person's sixty-fifth (65th) birthday will continue, up to any benefit payments remaining in the Disability Income Benefit Period.

RESTORATION OF BENEFITS: After a Covered Person has received the Maximum Disability Income Benefit payments, benefits will be fully restored after forty-eight (48) consecutive months have elapsed from the last date of the last Monthly Disability Income Benefit payment. Once benefits are restored, any new Disability incurred must be as a result of a new Injury.

EXCLUSIONS

This Policy does not provide benefits for:

- Treatment, services or supplies which:
 - Are not Medically Necessary;
 - Are not prescribed by a Doctor as necessary to treat an Injury;
 - Are determined to be Experimental/Investigational in nature;
 - Are received without charge or legal obligation to pay;
- Intentionally self-inflicted Injury, violating or attempting to violate any duly enacted law.
- Injury by acts of war, whether declared or not.
- Injury received while traveling or flying by air, except as a fare-paying passenger on a regularly scheduled commercial airline.
- Dental treatment, except as specifically stated.
- Treatment of Sickness, disease or infections, except pyogenic infections or bacterial infections which result from the accidental ingestion of contaminated substances.
- Suicide or attempted suicide while sane; or self-destruction or an attempt to self-destroy while insane.
- Injury sustained while committing or attempting to commit a felony.
- Injury sustained while voluntarily participating in a riot or civil commotion or disturbance of any kind.
- Loss occurring while the Covered Person is incarcerated if the incarceration is during a period of legal incarceration in a penal or correctional institution of more than seven (7) days or during a period of legal detainment of more than seven (7) days.
- Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay.
- 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.
- Loss resulting from an Accident where the Covered Person is the operator of a motor vehicle and did not possess a current and valid driver's license to operate that class of vehicle at the time of the Accident.
- Loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a Doctor.
- Injury which occurs while a Covered Person is on active duty service in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond thirty-one (31) days.
- Cosmetic surgery, except for reconstructive surgery on an injured part of the body.
- Loss resulting from competing in motor sport or water sport races or competitions.
- Loss resulting from testing cars/trucks on any racetrack or speedway.
- Loss resulting from handling, storing or transporting explosives.

EXCLUSIONS (Continued)

- Loss resulting from spelunking (exploring caves); or scaling up or down cliffs or mountain walls.
- Loss resulting from practice for or participation in a rodeo.
- Injury sustained flying in an ultra light, hang gliding, parachuting, bungee cord jumping.
- Injuries incurred outside of the United States or its possessions, unless such loss is incurred while the Covered Person is on a trip of not more than 60 days.

PREMIUM AND REINSTATEMENT

Payment of Premium. The first premium on Your policy is payable on the Effective Date. After that, premiums are payable in the amount and mode shown on the Policy Schedule. Payments may be made at Our Home Office in Glenview, IL

If We accept a premium, this Policy will continue in force until the end of the term for which that premium was due.

The amount of the first premium is shown in the Policy Schedule and is based on Your initial mode of payment. The amount of each premium after the first is based on Your then current mode of payment and the premium then being charged for policies of this form number and premium classification issued in the same state.

Grace Period. This Policy has a grace period of thirty-one (31) days for paying a premium. During the grace period, this Policy will remain in force. If a premium is not paid during the grace period, this Policy will terminate as of the due date of the premium.

Reinstatement. If a premium is not paid before the grace period ends, this Policy will lapse. Later acceptance of a premium by Us without asking for an application for reinstatement will reinstate this Policy as of 12:01 (Standard Time) on the day after the date We receive the premium.

If You are asked for an application, a conditional receipt for the premium will be given to You. If the application is approved, this Policy will be reinstated as of 12:01 (Standard Time) on the day after the date the reinstatement application is approved. Lacking such approval, this Policy will be reinstated on the 45th day after the date of the receipt unless We write You of Our disapproval before that date.

If reinstated, this Policy will only cover loss sustained after the date of reinstatement. In all other ways, Your rights and Ours will remain the same subject to any provision of the reinstatement. Premium will be applied as of the date of reinstatement.

Refund of Premium: We will refund that part of any premium paid beyond the end of the month in which Your death occurred. Payment will be made within 30 days after Our receipt of proof of Your death.

CLAIM PROVISIONS

Notice of Claim. Written notice of claim must be sent to Us at Our Home Office or to an authorized agent within thirty (30) days after the start of a loss. Such notice must include Your name and policy number. If notice cannot be given within that time, You must send the notice as soon as reasonably possible.

Claim Forms: When We receive notice of a claim, We will send forms for filing Proof of Loss. If We do not send these forms within fifteen (15) days, You will meet the Proof of Loss requirements by giving Us a written statement of the nature and extent of the loss within the time stated in the Proof of Loss section.

Proof of Loss. Written Proof of Loss must be given to Us within ninety (90) days of such loss. If it was not reasonably possible to give Us written proof in the time required, We will not reduce or deny the claim for this reason if the proof is filed as soon as reasonably possible. Unless You are legally unable to act, proof must be sent no later than one (1) year after the time specified.

Payment of Claims. When We receive written proof of loss covered by this Policy, We will pay any benefits due to You or else to Your beneficiary.

You are the beneficiary of all other Covered Persons. Your beneficiary is Your spouse, if living, otherwise Your surviving children; otherwise Your estate. Only You have the right to change Your beneficiary.

If benefits are payable to Your estate or to an insured or beneficiary who is a minor or otherwise not competent to give a valid release, We may pay up to \$1,000 to any relative by blood or connection by marriage of the insured or beneficiary who is deemed by Us to be equitably entitled thereto. Any payment made by Us in good faith pursuant to this provision shall fully discharge Us to the extent of such payment.

CLAIM PROVISIONS (Continued)

Time of Payment of Claims. After We receive satisfactory written proof of loss:

1. We will pay any benefits then due that are not payable periodically; and
2. We will pay at the end of each thirty (30) days any benefits due that are payable periodically, subject to continuing proof of loss.

Physical Examination and Autopsy. We, at Our own expense, have the right to have a Doctor of Our choice examine a Covered Person as often as reasonably necessary while a claim is pending. We may also have an autopsy made unless prohibited by law.

Assignment. Unless it is in writing and sent to Us at Our Home Office, no assignment of this Policy or its benefits, by You or Your legal representative will affect Us. We are not responsible for the validity of the assignment. Any payment We make in good faith will end Our liability to the extent of the payment.

Legal Action. No legal action may be brought to recover on this Policy until sixty (60) days after written proof of loss has been given as required. No such action may be brought after three (3) years from the time written proof of loss was required to be given.

GENERAL PROVISIONS

Entire Contract Changes. This policy with the application and attached papers is the entire contract between You and Us. No change in this Policy will be effective until approved by one of Our officers. This approval must be noted on or attached to this Policy. No agent may change this Policy or waive any of its provisions.

Misstatement of Age: If the age of a Covered Person has been misstated, the benefits will be those the premium paid would have purchased at the correct age. If the correct age is such that We would not have insured the person under this Policy, or such that the coverage would have terminated, We will refund all premiums paid for the period not covered, and We will not pay any claims incurred during that period.

Term. The first term begins at 12:01 a.m. (Standard Time) on the Effective Date shown on the policy schedule, but insurance will not be effective prior to the time the application is signed by the applicant. The first term ends at 12:00 midnight (Standard Time) on the First Renewal Date. Each renewal term begins at 12:01 a.m. (Standard Time) on the day after the date to which premium is paid. Renewal dates are determined by Your mode of payment. Your initial mode of payment is shown in the Policy Schedule

Time Limit on Certain Defenses. We rely on the statements made in the application when issuing this insurance. After this insurance has been in force for two (2) years, only fraudulent misstatements in the application may be used to void this Policy or deny any claim for loss which starts after the two (2) year period.

Conformity with State Statutes. Any provision of this Policy which, on the Effective Date, is in conflict with the laws of the State in which You reside is amended to conform to the minimum requirements of those laws.

Annual Meeting: The annual meeting of Our Policyholders will be held in Our home office. It will start at 10:00 a.m. on the first Monday in July. It will be held on Tuesday if Monday is a legal holiday. We will elect Directors and transact other business that is brought before the meeting.

BENEFITS SCHEDULE – PLAN A

This is a summary of Benefits. Please read your entire policy for further explanations and limitations.

ACCIDENT BENEFITS

Hospital Confinement

Daily Benefit Amount days 1 through 90	\$100/day
Daily Benefit Amount beginning with the 91 st consecutive day through 365 th day	\$200/day

First Occurrence Confinement \$500 Per Accident, Up To 2 Payments Per Calendar Year

Ambulance

Ground	\$250 Per Accident, Up to 4 Payments Per Calendar Year
Air Transport	\$1,000 Per Accident and Per Calendar Year

Emergency Room \$100 Per Accident, Up To 4 Payments Per Calendar Year

Emergency Medical / Dental / Chiropractic \$25 Per Visit
Limited To A Combined Total of Six Visits Per Calendar Year For All Medical, Dental and Chiropractic Visits

Outpatient Therapy \$50 Per Visit
Limited to a Combined Total of Six Visits For All Covered Therapies Per Accident

Surgical Procedures - Limited To One Payment Per Accident
Outpatient \$250

Fracture

See Fractures Schedule, Limit One Payment Per Accident, Up To 4 Payments Per Calendar Year

Prosthesis \$2,000, One Prosthetic Per Accident

Accidental Death Benefit – Primary Insured \$15,000

[Accidental Death Benefit – Dependent Spouse \$15,000]

[Accidental Death Benefit – Dependent Child \$ 2,000]

Accidental Dismemberment:

A. Loss of Both Hands, Both Feet, or Sight in Both Eyes:	\$10,000
B. Loss of One Hand, One Foot, or Sight in One Eye:	\$ 5,000
C. Loss of One or More Fingers and/or Toes:	\$ 500
Maximum Payout Per Accident (A, B, and C)	\$20,000

DISABILITY INCOME BENEFITS

Monthly Disability Income Benefit:	\$500
Maximum Disability Income Benefits:	up to, 12 Months
Disability Income Benefit Period Per Period of Disability:	up to, 6 months
Elimination Period Per Period of Disability:	90 Consecutive Days

BENEFIT SCHEDULE PLAN A (Continued)

FRACTURE BENEFIT SCHEDULE

If more than one fracture is sustained as a result of Injury, we will pay the highest benefit amount associated with the sustained fracture. If the fracture sustained is not shown in this Benefit Schedule, we will pay the benefit amount most comparable (from the list below) for such fracture.

Fracture Type	Benefit Amount (Open/Compound Fracture)	Benefit Amount (Closed Fracture)
Skull (depressed)	\$2,500	\$1,250
Skull (simple)	\$1,000	\$ 500
Hip/Thigh	\$1,500	\$ 750
Leg	\$ 800	\$ 400
Foot/Ankle/Kneecap	\$ 300	\$ 150
Vertebrae (body) or Pelvis (excluding Coccyx)	\$ 800	\$ 400
Vertebrae Processes	\$ 300	\$ 150
Coccyx	\$ 200	\$ 100
Upper Jaw, Upper Arm or Face (excluding nose)	\$ 350	\$ 175
Lower Jaw (mandible)	\$ 300	\$ 150
Shoulder Blade or Collarbone	\$ 300	\$ 150
Wrist, Forearm or Hand (excluding fingers)	\$ 300	\$ 150
Rib	\$ 250	\$ 125

BENEFITS SCHEDULE – PLAN B

This is a summary of Benefits. Please read your entire policy for further explanations and limitations.

ACCIDENT BENEFITS

Hospital Confinement

Daily Benefit Amount days 1 through 90 \$200/day
Daily Benefit Amount beginning with the 91st consecutive day through 365th day \$400/day

First Occurrence Confinement \$1,000 Per Accident, Up To 2 Payments Per Calendar Year

Ambulance

Ground \$250 Per Accident, Up to 4 Payments Per Calendar Year
Air Transport \$1,000 Per Accident and Per Calendar Year

Emergency Room \$200 Per Accident, Up To 4 Payments Per Calendar Year

Emergency Medical / Dental / Chiropractic \$25 Per Visit
Limited To A Combined Total of Six Visits Per Calendar Year For All Medical, Dental and Chiropractic Visits

Outpatient Therapy \$50 Per Visit
Limited to a Combined Total of Six Visits For All Covered Therapies Per Accident

Surgical Procedures - Limited To One Payment Per Accident
Outpatient \$500

Fracture

See Fractures Schedule, Limit One Payment Per Accident, Up To 4 Payments Per Calendar Year

Prosthesis \$4,000, One Prosthetic Per Accident

Accidental Death Benefit – Primary Insured \$30,000

[Accidental Death Benefit – Dependent Spouse \$30,000]

[Accidental Death Benefit – Dependent Child \$ 4,000]

Accidental Dismemberment:

A. Loss of Both Hands, Both Feet, or Sight in Both Eyes: \$20,000
B. Loss of One Hand, One Foot, or Sight in One Eye: \$10,000
C. Loss of One or More Fingers and/or Toes: \$1,000
Maximum Payout Per Accident (A, B, and C) \$40,000

DISABILITY INCOME BENEFITS

Monthly Disability Income Benefit: \$1,000
Maximum Disability Income Benefits: up to, 12 Months
Disability Income Benefit Period Per Period of Disability: up to, 6 months
Elimination Period Per Period of Disability: 90 Consecutive Days

BENEFIT SCHEDULE PLAN B (Continued)**FRACTURE BENEFIT SCHEDULE**

If more than one fracture is sustained as a result of Injury, we will pay the highest benefit amount associated with the sustained fracture. If the fracture sustained is not shown in this Benefit Schedule, we will pay the benefit amount most comparable (from the list below) for such fracture.

Fracture Type	Benefit Amount (Open/Compound Fracture)	Benefit Amount (Closed Fracture)
Skull (depressed)	\$5,000	\$2,500
Skull (simple)	\$2,000	\$1,000
Hip/Thigh	\$3,000	\$1,500
Leg	\$1,600	\$ 800
Foot/Ankle/Kneecap	\$ 600	\$ 300
Vertebrae (body) or Pelvis (excluding Coccyx)	\$1,600	\$ 800
Vertebrae Processes	\$ 600	\$ 300
Coccyx	\$ 400	\$ 200
Upper Jaw, Upper Arm or Face (excluding nose)	\$ 700	\$ 350
Lower Jaw (mandible)	\$ 600	\$ 300
Shoulder Blade or Collarbone	\$ 600	\$ 300
Wrist, Forearm or Hand (excluding fingers)	\$ 600	\$ 300
Rib	\$ 500	\$ 250

BENEFITS SCHEDULE – PLAN C

This is a summary of Benefits. Please read your entire policy for further explanations and limitations.

ACCIDENT BENEFITS

Hospital Confinement

Daily Benefit Amount days 1 through 90 \$300/day
Daily Benefit Amount beginning with the 91st consecutive day through 365th day \$600/day

First Occurrence Confinement \$1,500 Per Accident, Up To 2 Payments Per Calendar Year

Ambulance

Ground \$250 Per Accident, Up to 4 Payments Per Calendar Year
Air Transport \$1,000 Per Accident and Per Calendar Year

Emergency Room \$300 Per Accident, Up To 4 Payments Per Calendar Year

Emergency Medical / Dental / Chiropractic \$25 Per Visit
Limited To A Combined Total of Six Visits Per Calendar Year For All Medical, Dental and Chiropractic Visits

Outpatient Therapy \$100 Per Visit
Limited to a Combined Total of Six Visits For All Covered Therapies Per Accident

Surgical Procedures - Limited To One Payment Per Accident

Outpatient \$750

Fracture

See Fractures Schedule, Limit One Payment Per Accident, Up To 4 Payments Per Calendar Year

Prosthesis \$6,000, One Prosthetic Per Accident

Accidental Death Benefit – Primary Insured \$45,000

[Accidental Death Benefit – Dependent Spouse \$45,000]

[Accidental Death Benefit – Dependent Child \$ 6,000]

Accidental Dismemberment:

A. Loss of Both Hands, Both Feet, or Sight in Both Eyes: \$30,000
B. Loss of One Hand, One Foot, or Sight in One Eye: \$15,000
C. Loss of One or More Fingers and/or Toes: \$1,500
Maximum Payout Per Accident (A, B, and C) \$60,000

DISABILITY INCOME BENEFITS

Monthly Disability Income Benefit: \$2,000
Maximum Disability Income Benefits: up to, 12 Months
Disability Income Benefit Period Per Period of Disability: up to, 6 months
Elimination Period Per Period of Disability: 90 Consecutive Days

BENEFIT SCHEDULE PLAN C (Continued)

FRACTURE BENEFIT SCHEDULE

If more than one fracture is sustained as a result of Injury, we will pay the highest benefit amount associated with the sustained fracture. If the fracture sustained is not shown in this Benefit Schedule, we will pay the benefit amount most comparable (from the list below) for such fracture.

Fracture Type	Benefit Amount (Open/Compound Fracture)	Benefit Amount (Closed Fracture)
Skull (depressed)	\$7,500	\$3,750
Skull (simple)	\$3,000	\$1,500
Hip/Thigh	\$4,500	\$2,250
Leg	\$2,400	\$1,200
Foot/Ankle/Kneecap	\$ 900	\$ 450
Vertebrae (body) or Pelvis (excluding Coccyx)	\$2,400	\$1,200
Vertebrae Processes	\$ 900	\$ 450
Coccyx	\$ 600	\$ 300
Upper Jaw, Upper Arm or Face (excluding nose)	\$1,050	\$ 525
Lower Jaw (mandible)	\$ 900	\$ 450
Shoulder Blade or Collarbone	\$ 900	\$ 450
Wrist, Forearm or Hand (excluding fingers)	\$ 900	\$ 450
Rib	\$ 750	\$ 375

BENEFITS SCHEDULE – PLAN D

This is a summary of Benefits. Please read your entire policy for further explanations and limitations.

ACCIDENT BENEFITS

Hospital Confinement

Daily Benefit Amount days 1 through 90 \$400/day
Daily Benefit Amount beginning with the 91st consecutive day through 365th day \$800/day

First Occurrence Confinement \$2,000 Per Accident, Up To 2 Payments Per Calendar Year

Ambulance

Ground \$250 Per Accident, Up to 4 Payments Per Calendar Year
Air Transport \$1,000 Per Accident and Per Calendar Year

Emergency Room \$400 Per Accident, Up To 4 Payments Per Calendar Year

Emergency Medical / Dental / Chiropractic \$25 Per Visit
Limited To A Combined Total of Six Visits Per Calendar Year For All Medical, Dental and Chiropractic Visits

Outpatient Therapy \$100 Per Visit
Limited to a Combined Total of Six Visits For All Covered Therapies Per Accident

Surgical Procedures - Limited To One Payment Per Accident

Outpatient \$1,000

Fracture

See Fractures Schedule, Limit One Payment Per Accident, Up To 4 Payments Per Calendar Year

Prosthesis \$8,000, One Prosthetic Per Accident

Accidental Death Benefit – Primary Insured \$60,000

[Accidental Death Benefit – Dependent Spouse \$60,000]

[Accidental Death Benefit – Dependent Child \$ 8,000]

Accidental Dismemberment:

A. Loss of Both Hands, Both Feet, or Sight in Both Eyes: \$40,000
B. Loss of One Hand, One Foot, or Sight in One Eye: \$20,000
C. Loss of One or More Fingers and/or Toes: \$2,000
Maximum Payout Per Accident (A, B, and C) \$80,000

DISABILITY INCOME BENEFITS

Monthly Disability Income Benefit: \$2,000
Maximum Disability Income Benefits: up to, 12 Months
Disability Income Benefit Period Per Period of Disability: up to, 6 months
Elimination Period Per Period of Disability: 90 Consecutive Days

BENEFIT SCHEDULE PLAN D (Continued)

FRACTURE BENEFIT SCHEDULE

If more than one fracture is sustained as a result of Injury, we will pay the highest benefit amount associated with the sustained fracture. If the fracture sustained is not shown in this Benefit Schedule, we will pay the benefit amount most comparable (from the list below) for such fracture.

Fracture Type	Benefit Amount (Open/Compound Fracture)	Benefit Amount (Closed Fracture)
Skull (depressed)	\$10,000	\$5,000
Skull (simple)	\$ 4,000	\$2,000
Hip/Thigh	\$ 6,000	\$3,000
Leg	\$ 3,200	\$1,600
Foot/Ankle/Kneecap	\$ 1,200	\$ 600
Vertebrae (body) or Pelvis (excluding Coccyx)	\$ 3,200	\$1,600
Vertebrae Processes	\$ 1,200	\$ 600
Coccyx	\$ 800	\$ 400
Upper Jaw, Upper Arm or Face (excluding nose)	\$ 1,400	\$ 700
Lower Jaw (mandible)	\$ 1,200	\$ 600
Shoulder Blade or Collarbone	\$ 1,200	\$ 600
Wrist, Forearm or Hand (excluding fingers)	\$ 1,200	\$ 600
Rib	\$ 1,000	\$ 500

BENEFITS SCHEDULE – PLAN E

This is a summary of Benefits. Please read your entire policy for further explanations and limitations.

ACCIDENT BENEFITS

Hospital Confinement

Daily Benefit Amount days 1 through 90 \$500/day
Daily Benefit Amount beginning with the 91st consecutive day through 365th day \$1,000/day

First Occurrence Confinement \$2,500 Per Accident, Up To 2 Payments Per Calendar Year

Ambulance

Ground \$250 Per Accident, Up to 4 Payments Per Calendar Year
Air Transport \$1,000 Per Accident and Per Calendar Year

Emergency Room \$500 Per Accident, Up To 4 Payments Per Calendar Year

Emergency Medical / Dental / Chiropractic

\$25 Per Visit

Limited To A Combined Total of Six Visits Per Calendar Year For All Medical, Dental and Chiropractic Visits

Outpatient Therapy

\$100 Per Visit

Limited to a Combined Total of Six Visits For All Covered Therapies Per Accident

Surgical Procedures - Limited To One Payment Per Accident

Outpatient \$1,250

Fracture

See Fractures Schedule, Limit One Payment Per Accident, Up To 4 Payments Per Calendar Year

Prosthesis

\$10,000, One Prosthetic Per Accident

Accidental Death Benefit – Primary Insured

\$75,000

[Accidental Death Benefit – Dependent Spouse

\$75,000]

[Accidental Death Benefit – Dependent Child

\$10,000]

Accidental Dismemberment:

A. Loss of Both Hands, Both Feet, or Sight in Both Eyes: \$50,000

B. Loss of One Hand, One Foot, or Sight in One Eye: \$25,000

C. Loss of One or More Fingers and/or Toes: \$2,500

Maximum Payout Per Accident (A, B, and C) \$100,000

DISABILITY INCOME BENEFITS

Monthly Disability Income Benefit:

\$2,500

Maximum Disability Income Benefits:

up to, 12 Months

Disability Income Benefit Period Per Period of Disability:

up to, 6 months

Elimination Period Per Period of Disability:

90 Consecutive Days

BENEFIT SCHEDULE PLAN E (Continued)

FRACTURE BENEFIT SCHEDULE

If more than one fracture is sustained as a result of Injury, we will pay the highest benefit amount associated with the sustained fracture. If the fracture sustained is not shown in this Benefit Schedule, we will pay the benefit amount most comparable (from the list below) for such fracture.

Fracture Type	Benefit Amount (Open/Compound Fracture)	Benefit Amount (Closed Fracture)
Skull (depressed)	\$12,500	\$6,250
Skull (simple)	\$ 5,000	\$2,500
Hip/Thigh	\$ 7,500	\$3,750
Leg	\$ 4,000	\$2,000
Foot/Ankle/Kneecap	\$ 1,500	\$ 750
Vertebrae (body) or Pelvis (excluding Coccyx)	\$ 4,000	\$2,000
Vertebrae Processes	\$ 1,500	\$ 750
Coccyx	\$ 1,000	\$ 500
Upper Jaw, Upper Arm or Face (excluding nose)	\$ 1,750	\$ 875
Lower Jaw (mandible)	\$ 1,500	\$ 750
Shoulder Blade or Collarbone	\$ 1,500	\$ 750
Wrist, Forearm or Hand (excluding fingers)	\$ 1,500	\$ 750
Rib	\$ 1,250	\$ 625

**GUARANTEE TRUST LIFE
INSURANCE COMPANY**
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