

SERFF Tracking Number: GRTT-128016839 State: Arkansas  
Filing Company: Guarantee Trust Life Insurance Company State Tracking Number:  
Company Tracking Number:  
TOI: H07I Individual Health - Specified Disease - Sub-TOI: H07I.001 Critical Illness  
Limited Benefit  
Product Name: APPH3A-11  
Project Name/Number: Specified Critical Illness Application/

## Filing at a Glance

Company: Guarantee Trust Life Insurance Company

Product Name: APPH3A-11 SERFF Tr Num: GRTT-128016839 State: Arkansas

TOI: H07I Individual Health - Specified Disease SERFF Status: Closed-Approved State Tr Num:

- Limited Benefit

Sub-TOI: H07I.001 Critical Illness

Co Tr Num:

State Status: FEES PAID

Filing Type: Form

Reviewer(s): Donna Lambert

Author: Ann Ryan

Disposition Date: 01/24/2012

Date Submitted: 01/24/2012

Disposition Status: Approved

Implementation Date Requested:

Implementation Date: 02/24/2012

State Filing Description:

## General Information

Project Name: Specified Critical Illness Application

Status of Filing in Domicile: Not Filed

Project Number:

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments: Will not be filed in IL, our state of domicile

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 01/24/2012

State Status Changed: 01/24/2012

Deemer Date:

Created By: Ann Ryan

Submitted By: Ann Ryan

Corresponding Filing Tracking Number:

Filing Description:

Individual Accident and Sickness

Application APPH3A-11

We are submitting the above referenced form for the Department's review and approval.

This form will replace application APPH3-11 which was recently approved by your Department on December 20, 2011 under Serff filing number GRTT-127906558.

The only change is in question number 2 on page 2. We have added "an assisted living facility" to the question.

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We would appreciate general approval of this application so that it may be used with similar products approved by your state. It is not our intention to make any changes that would cause this application to be out of compliance with any statutory requirements.

The application is in final print, subject to minor variations in formatting, duplexing, shading and fonts. In addition, the application may be reproduced electronically which could result in formatting changes. While every effort is made to submit filings without mistakes, the Company reserves the right to make corrections to any typographical errors such as misspellings or minor grammatical errors noted after filing and approval.

## Company and Contact

### Filing Contact Information

Ann Ryan, aryan@gtlic.com  
 1275 Milwaukee Ave. 847-904-5587 [Phone] 5587 [Ext]  
 Glenview, IL 60025 847-699-0093 [FAX]

### Filing Company Information

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

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## Filing Fees

Fee Required? Yes  
 Fee Amount: \$50.00  
 Retaliatory? No  
 Fee Explanation: AR fee is \$50, IL fee is \$50 per form  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Guarantee Trust Life Insurance Company	\$50.00	01/24/2012	55741826

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/24/2012	01/24/2012

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## Disposition

Disposition Date: 01/24/2012

Implementation Date: 02/24/2012

Status: Approved

Comment:

Rate data does NOT apply to filing.

SERFF Tracking Number: *GRTT-128016839* State: *Arkansas*  
 Filing Company: *Guarantee Trust Life Insurance Company* State Tracking Number:  
 Company Tracking Number:  
 TOI: *H071 Individual Health - Specified Disease - Limited Benefit* Sub-TOI: *H071.001 Critical Illness*  
 Product Name: *APPH3A-11*  
 Project Name/Number: *Specified Critical Illness Application/*

<b>Schedule</b>	<b>Schedule Item</b>	<b>Schedule Item Status</b>	<b>Public Access</b>
<b>Supporting Document</b>	Flesch Certification	Approved	Yes
<b>Supporting Document</b>	Application	Approved	Yes
<b>Supporting Document</b>	Health - Actuarial Justification	Approved	Yes
<b>Supporting Document</b>	Outline of Coverage	Approved	Yes
<b>Form</b>	Application	Approved	Yes

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## Form Schedule

**Lead Form Number: APPH3A-11**

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved 01/24/2012	APPH3A-11	Application/Enrollment Form	Application/Enrollment Form	Initial		45.000	APPH3A-11.pdf

**Application for Critical Care Insurance to: Guarantee Trust Life Insurance Company**  
 1275 Milwaukee Avenue, Glenview, IL 60025 (800) 338-7452

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

**Application for:**  **New Coverage**  **Reinstatement**  **Increase of Benefits**

If Reinstatement or Increase requested, please list GTL policy/certificate number(s) affected: \_\_\_\_\_

**A. APPLICANT(S) INFORMATION**

**MAIL POLICY TO:**  **AGENT**  **INSURED**

**APPLICANT**

1. Last Name \_\_\_\_\_ 2. First \_\_\_\_\_ 3. M.I \_\_\_\_\_  
 4. Social Security # \_\_\_\_\_ 5.  Male  Female 6. Age \_\_\_\_\_ 7. Date of birth \_\_\_\_\_  
 8. Have you used any tobacco products in the past 12 months?  Yes  No

**SPOUSE:**

9. Last Name \_\_\_\_\_ 10. First \_\_\_\_\_ 11. M.I \_\_\_\_\_  
 12. Social Security # \_\_\_\_\_ 13.  Male  Female 14. Age \_\_\_\_\_ 15. Date of Birth \_\_\_\_\_  
 16. Have you used any tobacco products in the past 12 months?  Yes  No

**DEPENDENTS:**

D1. Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I \_\_\_\_\_  
 Male  Female Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_  
 D2. Last Name \_\_\_\_\_ First \_\_\_\_\_ M.I \_\_\_\_\_  
 Male  Female Age \_\_\_\_\_ Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

For additional dependents, please attach a separate piece of paper, signed and dated by the applicant, including the above information for each dependent.

**CONTACT:**

17. Street Address \_\_\_\_\_  
 18. City \_\_\_\_\_ 19. State \_\_\_\_\_ 20. Zip Code \_\_\_\_\_  
 21. Telephone \_\_\_\_\_ 22. Email Address \_\_\_\_\_

**BENEFICIARY (Required Information):**

Primary Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_  
 Contingent Beneficiary \_\_\_\_\_ Relationship \_\_\_\_\_

**B. COVERAGE SELECTION & PREMIUMS**

1. Choose a Plan:	2. Choose Benefit Amount	3. Choose Benefit Period
<b>Plan Type (Select 1):</b> A B C	<b>*Monthly Base Benefit Amount:</b> *Minimum \$500, maximum \$3,000 in \$250 increments	<b>**Maximum Benefit Period for covered conditions:</b> 6 Months   12 Months   18 Months   24 Months
Applicant: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	\$ _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Spouse: <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	\$ _____	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
Depndt(s): <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	\$500 (for all dependents)	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>
<i>Plan A = Critical Care Plan B = Cancer Care+ Plan C = Cardiac Care+</i>	<i>Assisted Living Facility and Nursing Home Benefits are paid in addition to the base. The ALF benefit is 50% of the base, NH benefit is 100% of the base.</i>	<i>**Limited Benefit Period applies to specific covered conditions. See Outline of Coverage.</i>

**4. Choose Premium Payment Mode:**

Monthly Bank Draft  Annual  
 Semi-Annual  Quarterly  
 Effective Date: \_\_\_\_\_  
 Draft Date (other than the 29th, 30th and 31st): \_\_\_\_\_

**5. Return of Premium Rider:**  Yes  No

**6. Premiums:**

Premiums include an annual \$25 Policy Fee.  
 TOTAL: \$ \_\_\_\_\_

**C. PRE QUALIFICATION, MEDICAL INFORMATION & EXCLUSIONS**

1. In the past 10 years has any person to be insured had, been diagnosed as having, received medication for or been treated by a medical practitioner for:
 

AIDS or ARC	Kidney Dialysis
ALS (Lou Gehrig's Disease)	Kidney Disease, Chronic
Alzheimer's Disease	Liver Disease, Chronic
Central Nervous System Disease	Mental Retardation
Cerebral Palsy	Motor Neuron Disease
Cirrhosis	Multiple Sclerosis
Crohn's Disease	Muscular Dystrophy
Cystic Fibrosis	Paralysis
Dementia	Parkinson's Disease
Hepatitis B, or C. Chronic	Respiratory or Lung Disease, Chronic
HIV positive	(other than controlled asthma)
Huntington's Disease	Ulcerative Colitis
2. In the past 5 years has anyone proposed for insurance been treated for drug or alcohol abuse or abused alcohol or drugs or had abnormal test results relating to alcohol or drug use or are currently confined to an assisted living facility or a nursing home?
3. For any of the conditions listed in 1 and 4 A-B for which benefits are being applied for, within the past 24 months, has any person to be insured been advised to seek treatment or medical advice from a practitioner but has not yet done so or experienced any symptoms that would have caused an ordinarily prudent person to seek advice from a medical practitioner?
4. In the past 10 years has any person to be insured had, been diagnosed as having, received medication for or been treated by a medical practitioner for:
  - A. Leukemia, malignant melanoma, lymphoma, sarcoma, or any other type of cancer (excluding skin cancer) or any tumor of the brain?
  - B. Disease of the heart or heart valves, heart attack, chest pain, coronary bypass, angioplasty, stent placement, angina, heart arrhythmia requiring treatment, cardiomyopathy, congenital heart defect, abnormal heart test, stroke, Transient Ischemic Attack (TIA), peripheral vascular disease, unoperated aneurysm, brain hemorrhage or diabetes treated with insulin?
5. For anyone proposed for insurance under the age of 60, did 2 or more of your natural parent(s), sister(s), brother(s), either living or dead suffer from:
  - A. Cancer before the age of 60?
  - B. Stroke or heart disease or diabetes before the age of 60?

6. Is any person proposed for insurance taking any prescription medication? If yes please list below.

Name of Person	Name of Medication	Reason for Medication(s)	Dosage

**APPLICANT'S ANSWERS**

Question	YES	NO	Action _____
1, or 2, or 3	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," do not submit the application
4A, or 5A	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," Cancer Care coverage not available
4B, or 5B	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," Cardiac Care coverage not available
			} If both "YES", do not submit application

**SPOUSE'S ANSWERS**

Question	YES	NO	Action _____
1, or 2, or 3	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," Spouse does not qualify for benefits
4A, or 5A	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," Cancer Care coverage not available
4B, or 5B	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," Cardiac Care coverage not available
			} If both "YES", does not qualify for benefits

**DEPENDENT'S ANSWERS**

Question	YES	NO	Action _____
1, or 2, or 3	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," Dependent(s) _____ does/do not qualify for benefits
4A, or 5A	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," Cancer Care coverage not available
4B, or 5B	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," Cardiac Care coverage not available
			} If both "YES", does/do not qualify for benefits

**D. COVERAGE INFORMATION**

**APPLICANT**

1. Will any existing in force hospital, medical, or major medical insurance be replaced or changed if the proposed coverage is issued?  No  Yes (If "YES," please complete the Replacement Form.)  
If "YES," with which company? \_\_\_\_\_

**AGENT'S STATEMENT**

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

- Is, or
- Is not likely to replace or change existing insurance or annuities.

Agent's Name (Printed)

Agent Code

Agent's Signature

Agent's Email Address

Date

**AUTHORIZATION/AGREEMENT**

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 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) I (We) have paid the premium in full. I (We) understand that any changes in my (our) health conditions, if applicable, from the date of this application until insurance becomes effective, may result in the declination of my (our) coverage. No agent or other representative of GTL has required, permitted, or encouraged me (us) to answer any question inaccurately or has waived any conditions of this application. I (We) have received a copy of the Pre-Notice which describes how information is obtained and used by GTL. If this application is completed electronically, I (We) understand the Pre-Notice will be delivered electronically or with the policy. If the application is completed over the phone the Pre-Notice will be delivered with the policy.

AUTHORIZATION: I (We) authorize Guarantee Trust Life Insurance Company (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company, pharmacy benefit managers, pharmacies, pharmacy-related facilities or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from the MIB, Inc. This Authorization includes all information about drugs, alcoholism, and mental illness. I (We) understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. Although federal regulations require that the Company inform Me (Us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. I (We) agree 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.

**AUTHORIZATION/AGREEMENT (CONTINUED)**

I (We) understand that I (We) have the right to revoke this Authorization, in writing, at any time by sending written modification 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

\_\_\_\_\_  
Signature of Applicant Signature of Applicant's Spouse (if applicable)

APPH3A-11

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## Supporting Document Schedules

	Item Status:	Status Date:
<b>Satisfied - Item:</b> Flesch Certification <b>Comments:</b> Readability certification <b>Attachment:</b> Readability Certification (APPH3A-11).pdf	Approved	01/24/2012
<b>Bypassed - Item:</b> Application <b>Bypass Reason:</b> See Form Tab. This is a new application. <b>Comments:</b> APPH3A-11	Approved	01/24/2012
<b>Bypassed - Item:</b> Health - Actuarial Justification <b>Bypass Reason:</b> Not applicable <b>Comments:</b>	Approved	01/24/2012
<b>Bypassed - Item:</b> Outline of Coverage <b>Bypass Reason:</b> Not applicable <b>Comments:</b>	Approved	01/24/2012

**CERTIFICATE OF READABILITY**

Form Number(s):  APPH3A-11

Flesch Test Score(s):  45.0

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



\_\_\_\_\_  
Robert Baluk, General Counsel

Date:  January 24, 2012