

SERFF Tracking Number: GRTT-128519381 State: Arkansas  
Filing Company: Guarantee Trust Life Insurance Company State Tracking Number:  
Company Tracking Number: G1181  
TOI: H13I Individual Health - Short Term Care Sub-TOI: H13I.002 Nursing Home  
Product Name: Recovery Care  
Project Name/Number: Recovery Care/G1181

## Filing at a Glance

Company: Guarantee Trust Life Insurance Company

Product Name: Recovery Care

SERFF Tr Num: GRTT-128519381 State: Arkansas

TOI: H13I Individual Health - Short Term Care

SERFF Status: Closed-Approved-  
Closed State Tr Num:

Sub-TOI: H13I.002 Nursing Home

Co Tr Num: G1181

State Status: Approved-Closed

Filing Type: Form/Rate

Reviewer(s): Rosalind Minor

Authors: Paul Porcaro, Mary Kole,  
Jeffrey Kollum

Disposition Date: 06/27/2012

Date Submitted: 06/27/2012

Disposition Status: Approved-  
Closed

Implementation Date Requested: On Approval

Implementation Date:

State Filing Description:

## General Information

Project Name: Recovery Care

Status of Filing in Domicile: Pending

Project Number: G1181

Date Approved in Domicile:

Requested Filing Mode: Review & Approval

Domicile Status Comments:

Explanation for Combination/Other:

Market Type: Individual

Submission Type: New Submission

Individual Market Type:

Overall Rate Impact:

Filing Status Changed: 06/27/2012

State Status Changed: 06/27/2012

Deemer Date:

Created By: Jeffrey Kollum

Submitted By: Jeffrey Kollum

Corresponding Filing Tracking Number:

Filing Description:

June 27, 2012

State of Arkansas

Department of Insurance

1200 West Third Street

Little Rock, AR, 72201-1904

RE: Company Filing Number: G1181

SERFF Tracking Number: GRTT-128519381 State: Arkansas  
Filing Company: Guarantee Trust Life Insurance Company State Tracking Number:  
Company Tracking Number: G1181  
TOI: H131 Individual Health - Short Term Care Sub-TOI: H131.002 Nursing Home  
Product Name: Recovery Care  
Project Name/Number: Recovery Care/G1181

Guarantee Trust Life Insurance Company  
FEIN #: 36-1174500 NAIC #: 64211  
Individual Health Short-Term Care

We are submitting the captioned forms for the Department's review and approval. These are new forms, and they do not replace any forms the Department approved before.

Form G1181-AR: Short-Term Nursing Home Care Indemnity Insurance Policy -- An individual policy that provides short-term health benefits for covered services while the insured person resides in a nursing home or an assisted living facility.

Form APPH9-11: Application for Short-Term Nursing Home Care Indemnity Insurance Policy

Form OCG1181: Outline of Coverage

Form RG11HHC: Short-Term Home Health Care Insurance Rider -- A rider, chosen at the option of the insured person - that provides limited benefits for short-term home health care covered services under the above-listed policy

Form RG11IPB: Simple Increasing Inflation Protection Benefit Rider

Form RG11IPG: Compound Increasing Inflation Protection Benefit Rider

Actuarial Memorandum, Rates, and Loss Ratio Exhibit

We use multiple computer systems to generate documents. Therefore, actual issued forms may have a different font style than these submitted forms. 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 re-filing for a font style variation.

Your prompt review of this submission will be much appreciated. If I can provide additional information to assist you in your review, you may contact me collect using telephone number 1-847-904-5786, or by email at [jkoll@gtlic.com](mailto:jkoll@gtlic.com).

Very truly yours,

Jeffrey M. Kollum, MBA, CLU, GBA, LTCP  
Senior Compliance Analyst  
Product Approval and Compliance  
Guarantee Trust Life Insurance Company  
State Narrative:

## Company and Contact

### Filing Contact Information

Jeffrey Kollum, Senior Compliance Analyst      [jkoll@gtlic.com](mailto:jkoll@gtlic.com)

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1275 Milwaukee Avenue 847-904-5786 [Phone]  
 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: \$350.00  
 Retaliatory? Yes  
 Fee Explanation: IL is our domicile state. IL charges \$50 per form or rates, and so does AR.  
 The filing fee for this submission = 7 forms x \$50/form = \$350  
 Per Company: No

COMPANY	AMOUNT	DATE PROCESSED	TRANSACTION #
Guarantee Trust Life Insurance Company	\$350.00	06/27/2012	60447204

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## Correspondence Summary

### Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	06/27/2012	06/27/2012

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## Disposition

Disposition Date: 06/27/2012

Implementation Date:

Status: Approved-Closed

Comment:

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Guarantee Trust Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

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Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	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 Readability	Approved-Closed	Yes
Form	Short-Term Nursing Home Care	Approved-Closed	Yes
	Indemnity Insurance Policy		
Form	Application	Approved-Closed	Yes
Form	Outline of Coverage	Approved-Closed	Yes
Form	Short-Term Home Health Care Insurance	Approved-Closed	Yes
	Rider		
Form	Simple Increasing Inflation Protection	Approved-Closed	Yes
	Benefit Rider		
Form	Compound Increasing Inflation Protection	Approved-Closed	Yes
	Benefit Rider		
Rate	Actuarial Memorandum	Approved-Closed	No
Rate	Rates	Approved-Closed	Yes
Rate	Loss Ratio Exhibit	Approved-Closed	No

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## Form Schedule

### Lead Form Number: G1181

Schedule Item	Form Number	Form Type	Form Name	Action	Action Specific Data	Readability	Attachment
Approved-Closed 06/27/2012	G1181-AR	Policy/Contract	Short-Term Nursing Home Care Indemnity Insurance Certificate Policy	Initial		50.120	G1181-AR-Policy.pdf
Approved-Closed 06/27/2012	APPH9-11	Application/Enrollment Form	Application	Initial		55.840	Recovery Care Policy App April 30, 2012_VER 14.pdf
Approved-Closed 06/27/2012	OCG1181	Outline of Coverage	Outline of Coverage	Initial		50.040	OCG1181-Outline of Coverage.pdf
Approved-Closed 06/27/2012	RG11HHC	Policy/Contract	Short-Term Home Health Care Insurance Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		58.230	RG11HHC-Home Health Rider.pdf
Approved-Closed 06/27/2012	RG11IPB	Policy/Contract	Simple Increasing Inflation Protection Benefit Rider Certificate: Amendment, Insert Page, Endorsement or Rider	Initial		57.100	RG11IPB-Simple Inflation Rider.pdf
Approved-	RG11IPG	Policy/Contract	Compound	Initial		53.930	RG11IPG-

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Closed 06/27/2012 ract/Fratern Increasing Inflation Certificate: Rider Amendment, Insert Page, Endorsement or Rider Compound Inflation Rider.pdf

**GUARANTEE TRUST LIFE  
INSURANCE COMPANY**

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

**SHORT-TERM  
NURSING HOME CARE  
INDEMNITY INSURANCE  
POLICY**

**WE PROMISE** to insure you for the benefits described in this policy. Benefits are subject to this policy's definitions, provisions, limitations and exceptions. We make this promise in consideration of the application for this policy and payment of the premium.

This policy does not replace your present health insurance. This policy is **NOT A MEDICARE SUPPLEMENT** policy. If you are eligible for Medicare, review the Medicare Supplement Buyer's Guide.

**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 it by its due date or during the 31 days that follow. We cannot cancel or refuse to renew this policy or place any restrictions on it if you pay your premiums on time.

**POLICY OWNER:  
POLICY DATE:  
POLICY NUMBER:**

**PREMIUMS ARE SUBJECT TO CHANGE:** We may change your premium by giving you at least thirty-one (31) days prior written notice. We can only change premium if we change it for all policies like yours in your state on a class basis.

**EFFECTIVE DATE:** This policy begins at 12:01 a.m. Standard Time at your residence on the Effective Date shown in the policy schedule.

**CAUTION**

**This Insurance policy was issued based on your answers to the questions on your Application. A copy of your Application is attached. If your answers are incorrect or untrue, we may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If for any reason, any of your answers are incorrect, contact us within 30 days at 1275 Milwaukee Avenue, Glenview, Illinois 60025.**

**If you have any questions concerning this coverage, or if we can be of any assistance, please call us at 1-800-338-7452. If We are unable to satisfy you, You may write to the Arkansas Consumer Services Division, Department of Insurance, 1200 W. Third Street, Little Rock, AR, 72201-1904, or call 800-282-9124.**

**JOHN DOE  
JANUARY 1, 2000  
GT A00001**

**YOUR RIGHT TO EXAMINE THIS POLICY FOR 30 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 30 days of its receipt. Upon return, we will void the policy as of the Effective Date and you will receive a full refund of any premium you have paid.

**READ YOUR POLICY CAREFULLY.** This policy is a legal contract between you and us.

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



Secretary  
President

**THIS SHORT-TERM NURSING HOME CARE INDEMNITY INSURANCE POLICY DOES NOT QUALIFY THE INSURED FOR THE FAVORABLE TAX TREATMENT PROVIDED FOR IN THE INTERNAL REVENUE CODE OF 1986, SECTION 7702(B) AS ENACTED BY THE "HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT" OF 1996.**

**NOTICE TO BUYER**

**THIS POLICY MAY NOT COVER ALL OF THE COSTS ASSOCIATED WITH SHORT-TERM NURSING HOME CARE INCURRED BY THE BUYER DURING THE PERIOD OF COVERAGE. THE BUYER IS ADVISED TO REVIEW CAREFULLY ALL POLICY LIMITATIONS AND EXCEPTIONS.**

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

**POLICY SCHEDULE**

POLICY NUMBER:GTA00000	EFFECTIVE DATE:	January 1, 2012
INSURED: John Doe	AGE AT ISSUE:	60
STATE OF ISSUE: IL	MODE SELECTED:	ANNUAL
INITIAL PREMIUM AMOUNT:\$XXXX		

**SHORT-TERM NURSING HOME CARE:**

DAILY BENEFIT AMOUNT:	\$[50-300]
ELIMINATION PERIOD:	[0,20] DAYS
BENEFIT PERIOD:	[30,45,60,90,180,360] DAYS
MAXIMUM BENEFIT PERIOD:	EQUAL TO [2] BENEFIT PERIODS

**OPTIONAL RIDERS INCLUDED IN YOUR COVERAGE:**

[SHORT-TERM HOME HEALTH CARE:  
ELIMINATION PERIOD: [0,20] DAYS  
HOME HEALTH CARE DAILY BENEFIT AMOUNT PER VISIT: \$[25,50,75]  
HOME HEALTH CARE BENEFIT MAXIMUM: [90,180] VISITS]

[SIMPLE INFLATION RIDER --  
INFLATION PERIOD:LIFETIME]

[COMPOUND INFLATION RIDER --  
INFLATION PERIOD:LIFETIME]

COVERAGE	ANNUAL PREMIUM
SHORT-TERM NURSING HOME CARE;	\$XXX.XX
HOME HEALTH CARE RIDER:	\$XXX.XX
SIMPLE INFLATION RIDER:	\$XXX.XX
COMPOUND INFLATION RIDER:	\$XXX.XX
ANNUAL POLICY FEE	[\$25.00]
<b>TOTAL ANNUAL PREMIUM:</b>	<b>\$XXX.XX</b>

## **CONSIDERATION**

We have issued this policy in consideration of the application and payment of the first premium. The application and policy schedule are a part of this policy.

## **POLICY DEFINITIONS**

**Activities of Daily Living** means the following (6) basic activities of daily living:

1. **Bathing** means washing oneself by sponge bath in either a tub or shower, including the task of getting into or out of the tub or shower.
2. **Continence** means the ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
3. **Dressing** means the ability to put on or take off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. **Eating** means the ability to feed oneself by getting food into the body from a receptacle (e.g., plate, cup, table) or by a feeding tube or intravenously.
5. **Toileting** means the ability to get to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. **Transferring** means the ability to move into or out of a bed, chair or wheelchair without assistance.

**Any One Period of Care** begins when you first incur Covered Care under this policy. It ends when, for six consecutive months, you are no longer Functionally Disabled and you have been free of the need for any care or services for which benefits are payable under the policy. Then, provided this policy is in force, a new period of Covered Care may begin. The Any One Period of Care can be renewed only once during the life of the policy.

**Assisted Living Facility** means a place providing room, board and personal care services to persons in need of assistance because of a Functional Disability, but given at a level of care less intense than that which would be received in a Nursing Home. Assisted Living Facilities can include other facilities providing the same type of care and services, but are otherwise known as personal care, domiciliary care or residential health care facilities. An Assisted Living Facility does not include congregate housing, individual residences or independent living units. An Assisted Living Facility must:

1. provide 24 hour a day care and services for inpatients in one location;
2. have a trained and ready-to-respond employee on duty at all times to provide care;
3. provide 3 meals a day and accommodate special dietary needs;
4. be licensed by the appropriate licensing agency (if any) to provide such care;
5. have formal arrangements for the services of a Doctor or nurse to furnish emergency medical care; and
6. have appropriate methods and procedures for handling and administering drugs and biologicals.

**Benefit Period** means the maximum number of days available during Any One Period of Care for Covered Care incurred under the policy. It begins once the Elimination Period is satisfied. The Benefit Period is shown on the policy schedule.

Any days which remain unpaid during Any One Period of Care cannot be carried forward and added to the Benefit Period of the next Any One Period of Care.

## DEFINITIONS (Continued)

**Cognitive Impairment** means a deterioration or loss in intellectual capacity which requires Substantial Supervision to protect oneself from threats to health and safety. Cognitive Impairment is measured by clinical evidence and standardized tests that reliably measure impairment in one's: (1) short or long-term memory; (2) orientation as to people, places, or time; and (3) deductive or abstract reasoning.

Such loss of intellectual capacity can result from the following covered conditions: Alzheimer's Disease, Parkinson's Disease, senile dementia or other nervous or mental disorders of organic origin.

**Covered Care** is defined and limited below in the provisions titled Part C.

**Daily Benefit Amount** means the amount we'll pay you per day, after any applicable Elimination Period, for all benefits available under this policy, in any combination. The Daily Benefit Amount is shown on the Policy Schedule.

**Doctor** means any licensed practitioner of the healing arts operating within the scope of his or her license in treating any Injury or Sickness. It doesn't include a member of the Immediate Family.

**Elimination Period** means the number of days for which no benefits are payable under this policy. The Elimination Period must be satisfied once during the life of the policy and can only be satisfied by days on which you incur Covered Care for which payment would be made under this policy if there were no Elimination Period. The Elimination Period applies to days on which you incur Covered Care for confinement in a Nursing Home Facility, or Assisted Living Facility. The Elimination Period is shown on the policy schedule and will only be applied once during the life of the policy.

**Functionally Disabled/Functional Disability** means an Insured who is:

1. unable to perform at least 2 Activities of Daily Living without human assistance or supervision; or
2. requires Substantial Supervision to protect such individual from threats to health and safety due to Cognitive Impairment.

**Hospital** means a place which is defined as a Hospital and approved for payment as a Hospital by Medicare, or accredited as a Hospital by the Joint Commission on Accreditation of Health Care Organizations, the American Osteopathic Association, or the Commission on the Accreditation of Rehabilitation Facilities.

Hospital doesn't mean places that are primarily convalescent, nursing, rest or skilled nursing facilities, nor places that primarily treat the aged, drug addiction or alcoholism, including units in a Hospital used for such care.

**Immediate Family** means you or your spouse, you or your spouse's parents, grandparents, children, grandchildren, or siblings by blood or marriage.

**Injury** means bodily injury caused by an accident, exclusive of Sickness, which results in loss covered by this policy. The loss must begin while this policy is in force.

**Insured:** The person named in the Policy Application and Policy Schedule.

**Licensed Health Care Practitioner** means any licensed Doctor, registered professional nurse or licensed social worker. It doesn't include a member of the Immediate Family.

**Maximum Benefit Period** means the number of Benefit Periods you are eligible for under the terms of the policy as shown in the policy schedule.

## POLICY DEFINITIONS (Continued)

**Medicaid** means "The Health Insurance for the Aged Act, Title XIX of the Social Security Amendments of 1965 as Then Constituted or Later Amended."

**Medicare** means "The Health Insurance for the Aged Act, Title XVIII of the Social Security Amendments of 1965 as Then Constituted or Later Amended."

**Mental Illness** means a neurosis, psychoneurosis, psychopathy, psychosis, or mental or emotional disease or disorder of any kind classified in the American Psychiatric Association Diagnostic and Statistical Manual of Mental Disorders on the date care or medical treatment is rendered. It doesn't mean a demonstrable organic brain disease, such as Parkinson's Disease, Alzheimer's Disease or senile dementia.

**Nursing Home** means a facility that meets all of the following standards:

1. it is legally operated to provide nursing care (skilled, intermediate, custodial) for sick and injured persons at their own expense;
2. it is primarily engaged in providing, in addition to room and board accommodations, nursing care (skilled, intermediate, custodial) by or under the supervision of a duly licensed Doctor;
3. it provides continuous twenty-four (24) hour a day nursing services by or under the supervision of a registered professional nurse (RN); and
4. it maintains a daily medical record of each patient.

Nursing Home also means a wing, area or floor of a Hospital specifically set aside for nursing care.

**A Nursing Home is NOT:**

1. any home, facility, or part thereof used primarily for rest;
2. a home or facility for the aged or for the care and treatment of drug and alcohol abuse; or
3. a home or facility used for the care and treatment of mental or nervous disorders or educational care.

**Plan of Care** means a written individualized program of care developed, supervised and approved in writing by a Licensed Health Care Practitioner for a Functionally Disabled Insured. The Plan of Care must include but not be limited to; (a) the reason for confinement, including diagnosis, symptoms and reason for the need for continued care, (b) schedule of treatment, including level of care, (c) functional limitations, including deficiencies in Activities of Daily Living, and (d) objectives of the Plan of Care. We may require a copy of the initial Plan of Care and any changes later made to it.

**Sickness** means illness or disease which manifests itself after the Effective Date of this Policy and results in loss covered by this policy. Any loss due to Sickness must begin while this policy is in force.

**Substantial Supervision** means continual supervision by another person that is necessary to protect a Cognitively Impaired person from threats to his or her own health or safety (such supervision may include cueing by verbal prompting, gestures or other demonstrations).

**We, Our and Us** means Guarantee Trust Life Insurance Company.

**You, Your and Yours** means the Insured named in the policy schedule.

## **PRE-EXISTING CONDITIONS LIMITATION**

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Pre-existing conditions are those medical conditions disclosed or not disclosed on the application for which medical advice or treatment was recommended or received from a Doctor within 6 months prior to the Effective Date of your coverage.

Any loss due to a pre-existing condition isn't covered unless the loss begins more than 6 months after the Effective Date of coverage.

## **QUALIFYING FOR BENEFITS AND BENEFIT LIMITATIONS**

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### **A. QUALIFYING FOR BENEFITS**

Before benefits will be payable for Covered Care:

1. a Licensed Health Care Practitioner must certify that the services received for Covered Care available under this policy are needed pursuant to a Plan of Care;
2. You have a Functional Disability; and
3. You satisfy the Elimination Period, if any.

We may periodically review the necessity of care and treatment. Our review, for example, may include: (a) diagnosis, symptoms, complaints, and complications of a condition; (b) the reason for the services being rendered; (c) a Licensed Health Care Practitioner's orders; (d) schedule of treatment; (e) physical limitations and impairments; and (f) the objectives of the Licensed Health Care Practitioner's Plan of Care.

### **B. LIMITATION ON BENEFITS**

Subject to the Qualifying For Benefits provision above, we'll pay the Daily Benefit Amount for all Covered Care available under this policy. We'll pay for such Covered Care received during Any One Period of Care.

We won't pay more than the number of Benefit Period days, as shown in the policy schedule, during Any One Period of Care for all benefits available under this policy. Any One Period of Care can only be restored once during the life of the policy. Any days which remain unpaid during Any One Period of Care cannot be carried forward and added to the Benefit Period of the next Any One Period of Care.

We won't pay benefits for more days than are available under the Maximum Benefit Period during the life of the policy.

Covered Care is incurred on the date the service or treatment is given or the supply is bought. Covered Care must be incurred while this coverage is in force.

### **C. COVERED CARE MEANS:**

1. **Nursing Home Care:**  
The care (including room, board, services and supplies) provided for each day of care during a Nursing Home stay for all levels of care (skilled, intermediate, or custodial).
2. **Assisted Living Facility Care**  
  
The care (including room, board, services and supplies) provided during a stay in an Assisted Living Facility.

We will only pay one Daily Benefit Amount on any day You incur Nursing Home Care and Assisted Living Facility Care on the same day.

## EXCEPTIONS

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We won't pay for treatment, care, services or supplies which are:

1. due to war or act of war whether declared or not;
2. due to intentionally self-inflicted Injury while sane or insane;
3. for services or supplies provided by a member of the Immediate Family; an individual who normally resides with you on a regular basis; or in a facility owned or operated by a member of the Immediate Family;
4. for services and supplies not included in your Plan of Care;
5. for which no charge is customarily made in the absence of insurance;
6. for personal, comfort or convenience items furnished at the Insured's request, such as television, radio, or telephone;
7. for care received outside the United States or its territories; or
8. for alcoholism, drug addiction, or chemical dependency, unless as a result of a medication prescribed by a Doctor.

## CLAIM PROVISIONS

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**NOTICE OF CLAIM:** Written notice of claim must be sent to us at our Home Office, or to the agent, within sixty (60) days after you become Functionally Disabled. The notice must include your name and policy number. If notice cannot reasonably be given within that time, you must send the notice as soon as possible.

**WRITTEN PROOF OF CLAIM:** Written proof of claim must be sent to us within ninety (90) days after a Functional Disability begins. If it is not reasonably possible to give proof in the time required, your claim is not affected if proof is sent as soon as possible. Unless you are legally incapacitated, proof must be sent no later than one (1) year after the time specified.

**CLAIM FORMS:** We will send you claim forms when we receive written notice of claim. If forms are not received within fifteen (15) days after written notice of claim is sent, then proof of claim will be met by giving us a written statement of the type and the extent of the services. You must send such proof within the time limit stated in the Written Proof of Claim provision of this policy.

**PAYMENT OF CLAIMS:** When we receive proper written proof of claim covered by this policy, we will pay any benefits due. Benefits that provide for periodic payment will be paid monthly as we become liable.

We will pay benefits to you, if living, or to providers of care or services through an Assignment of Benefits, or to your estate. If benefits are payable to your estate, we may pay up to \$1,000.00 to any relative of yours who we find is entitled to them. Any payment made in good faith will fully discharge us to the extent of the payment.

We will investigate any instance of improper billing by a health care provider if you send us written notification within ninety (90) days of the date we receive proof of claim. When we verify that an error of at least \$500.00 has occurred, we will pay you \$100.00, not to exceed one (1) \$100.00 payment per calendar year.

**TIME OF PAYMENT OF CLAIMS:** Indemnities payable under this policy for any loss other than for loss for which this policy provides any periodic payment, will be paid immediately upon receipt of due written proof of such loss. If you are not satisfied with our handling of a claim or a portion of a claim, we will be happy to review the claim. You or your representative may send us a written request for a review together with any added claim facts or supporting material which should be considered. Within sixty (60) working days after receiving your request, we will give you the results of this review.

**PHYSICAL EXAMINATIONS:** We have the right to have a Doctor of our choice examine you as often as reasonably necessary while a claim is pending. Any such examinations will be made at our expense.

## CLAIM PROVISIONS (continued)

**LEGAL ACTIONS:** No legal action can be brought against us to recover on this policy within sixty (60) days after written proof of claim has been given as required by this policy. No action can be brought after the expiration of three (3) years after the time written proof of claim is received.

**CLAIM DENIAL:** If your claim is denied, we will make available all information directly relating to such denial within 60 days of your written request unless prohibited under state or federal law.

**APPEAL PROCEDURE:** If we deny a claim for benefits in whole or in part, you will be notified. The notification form will explain the reason(s) for denial.

If you disagree with our denial, you may request a formal review of the claim. The request must be in writing and sent to us within sixty (60) days after the denial. Such request must include the following information:

1. your name;
2. your policy number;
3. other identifying information found on the notice from us, if any;
4. a concise statement of issues; and
5. any information, documents, or comments that you may want to have considered.

The results of this review will be sent to you within sixty (60) days following our receipt of your request.

## 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 unless it has been 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.

**TIME LIMIT ON CERTAIN DEFENSES:** (a) We may void this policy or deny any claim for loss which starts within 6 months of this policy's Issue Date. We may do so only if we determine there was material misrepresentation which would have caused the application for this coverage to be declined; (b) After two (2) years from the Issue Date only fraudulent misstatements in the application relating to your health may be used to void this policy or deny any claim for loss which starts after the two (2) year period.

**GRACE PERIOD:** This policy has a grace period of thirty-one (31) days for paying a premium. During the grace period, this policy will stay in force. If a premium is not paid during the grace period, this policy will terminate as of the due date of the premium.

**NOTICE OF LAPSE:** We will provide you and any third party you have selected with notice of termination for nonpayment of premium 30 days after a premium is due. This notice shall be given by first class United States mail and shall not be given within thirty (30) days after the premium is due and unpaid. Notice shall be deemed to have been given as of five (5) days after the date of mailing.

### REINSTATEMENT OF THIS POLICY:

#### PART I

If this policy lapses, it may be reinstated at our option. In order to request reinstatement you must complete a reinstatement application, pay all premium then due, and return the application and premium to our Home Office for approval.

This policy will be put back in force on the date we approve your reinstatement application. If we fail to give you written notice of disapproval, this policy will be reinstated on the forty-fifth (45th) day after the date of our receipt of payment.

Except as provided for in Part II, the reinstated policy will cover only loss which results after the date of reinstatement.

In all other respects, your rights and Our rights under this policy will be the same as they were before this policy ended.

## GENERAL PROVISIONS (continued)

## PART II

In the event of lapse due to Functional Disability, you or any person authorized to act on your behalf, may request reinstatement of the policy. Such request must be made within five (5) months after this policy lapsed. If proof of Functional Disability is provided and medically verified, you may reinstate this policy without submitting to us evidence of insurability, subject to the payment of all past due premium. The reinstated policy will be considered to have remained in continuous force without lapse and will cover loss occurring from the date of lapse. Payment of premium must be made within 15 days following our request.

**PREMIUM REFUND AT DEATH:** If we receive notice of your death while this policy is in force, we will refund that part of any premium paid covering the period beyond your date of death. Payment will be made within 30 days after Our receipt of proof of your death.

**MISSTATEMENT OF AGE:** If your age has been misstated, the benefits payable under this policy will be those benefits, which the premium paid would have purchased at the correct age. If no coverage would have been available, we will refund any premium you have paid, less any claims paid.

**ASSIGNMENT OF BENEFITS:** No assignment of this policy or its benefits, by you or your legal representative, will affect us unless it is in writing and sent to us at our Home Office. 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.

**OTHER INSURANCE WITH US:** You may not have duplicate insurance of this kind in force with us at any one time. You may elect which policy you choose to be effective. We will refund all premiums paid, minus any claims paid or payable, for other policies in force during the same period.

**CONFORMITY WITH STATE LAWS:** Any provision of this policy which, on the Effective Date, is in conflict with the laws of the state in which it is delivered is amended to conform to minimum requirements of such 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.

**GUARANTEE TRUST LIFE  
INSURANCE COMPANY**

A Mutual Company  
1275 Milwaukee Avenue  
Glenview, Illinois 60025

**SHORT-TERM  
NURSING HOME CARE  
INDEMNITY INSURANCE POLICY**

**Application for Short-Term Nursing Home Care Indemnity Insurance Policy**  
**Guarantee Trust Life Insurance Company**  
 1275 Milwaukee Avenue Glenview, IL 60025 (800) 338-7452

**(A) 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: \_\_\_\_\_  
**APPLICANT(S) INFORMATION** **MAIL POLICY TO:**    **AGENT**    **INSURED**

**Applicant 1**

1. Last Name \_\_\_\_\_ 2. First \_\_\_\_\_ 3. M.I. \_\_\_\_\_  
 4. Social Security # \_\_\_\_\_ 5. Age \_\_\_\_\_ 6. Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 7. Height (ft/in) \_\_\_\_\_ 8. Weight \_\_\_\_\_ lbs 9.  Male  Female

**Applicant 2**

10. Last Name \_\_\_\_\_ 11. First \_\_\_\_\_ 12. M.I. \_\_\_\_\_  
 13. Social Security # \_\_\_\_\_ 14. Age \_\_\_\_\_ 15. Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
 16. Height (ft/in) \_\_\_\_\_ 17. Weight \_\_\_\_\_ lbs 18.  Male  Female

**Address**

19. Street Address \_\_\_\_\_ 20. City \_\_\_\_\_ 21. State \_\_\_\_ 22. Zip Code \_\_\_\_\_  
 23. Applicant 1 E-mail \_\_\_\_\_ 24. Applicant 2 E-mail \_\_\_\_\_  
 25. Applicant 1 Phone \_\_\_\_\_ 26. Applicant 2 Phone \_\_\_\_\_

**(B) Plan Applied For Applicant 1**

**Nursing Home/Assisted Living Facility**

1. **Select Daily Benefit Amount:**  
 \$50 - \$300/day (in \$10 dollar increments): \$ \_\_\_\_\_  
 2. **Benefit Period:**  
 30    45    60    90    180    360 Days  
 3. **Elimination Period:**  
 0 Days    20 Days

**(B) Plan Applied For Applicant 2**

**Nursing Home/Assisted Living Facility**

8. **Select Daily Benefit Amount:**  
 \$50 - \$300/day (in \$10 dollar increments): \$ \_\_\_\_\_  
 9. **Benefit Period:**  
 30    45    60    90    180    360 Days  
 10. **Elimination Period:**  
 0 Days    20 Days

**Inflation Rider**

4.  5% Simple Inflation    5% Compound Inflation

**Inflation Rider**

11.  5% Simple Inflation    5% Compound Inflation

**Home Health Rider:**

5. **Benefit Period:**  
 90 days    180 days  
 6. **Benefit Amount Per Visit:**  \$25    \$50    \$75  
 7. **Elimination Period:**  0 Days    20 Days

**Home Health Rider:**

12. **Benefit Period:**  
 90 days    180 days  
 13. **Benefit Amount Per Visit:**  \$25    \$50    \$75  
 14. **Elimination Period:**  0 Days    20 Days

**Choose Premium Payment Mode:**

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

**Premiums:**

Premiums include an annual \$25 Policy Fee (per applicant)  
 Applicant 1 Total Premium: \$ \_\_\_\_\_  
 Applicant 2 Total Premium: \$ \_\_\_\_\_

<b>(C) Pre-Qualification, Medical Information &amp; Exclusions</b>				<b>Applicant 1</b>	<b>Applicant 2</b>
<b>If any applicant answers "YES" to any questions 1, 2 or 3 A-H below, that applicant does not qualify for this coverage:</b>					
1. Is any applicant currently eligible for Medicaid or on early Medicare due to disability (prior to age 65) or disabled?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. In the past 10 years has any applicant been treated or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. In the past 24 months, has any applicant:					
A. Required the assistance or supervision of any kind to perform activities of daily living such as bathing, dressing, eating, toileting, getting in or out of bed or chair; have an inability to control bowel or bladder function; or need or use a wheelchair, walker, walking aids, scooter, or multi-pronged cane?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
B. Been confined or advised to enter a rehabilitation facility, nursing facility or assisted living facility; or received home health care services?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
C. Had a stroke, Transient Ischemic Attack (TIA); or congestive heart failure, heart or valve surgery or organ transplant (other than corneal)?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
D. Been diagnosed with, or treated for, insulin dependent diabetes or diabetes with neuropathy or with eye or kidney complications?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
E. Been diagnosed or treated for Alzheimer's disease, dementia, memory loss, Parkinson's disease, psychotic disorders, systemic lupus, Multiple Sclerosis, Muscular Dystrophy, cerebral palsy, ALS (Lou Gehrig's disease), or had an amputation due to a disease?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
F. Been diagnosed or treated for Chronic Obstructive Lung or Pulmonary disease; chronic bronchitis or emphysema; respiratory disease requiring the use of oxygen; kidney failure, renal insufficiency, or kidney dialysis; or chronic liver disease?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
G. Been diagnosed or treated for cancer (other than skin cancer), leukemia, lymphoma or malignant melanoma or cancer that has spread from its original site; or alcohol or drug abuse or crippling or rheumatoid arthritis?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
H. Been advised to have tests or medical treatment or surgery that has not been performed or for which results have not been given?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. In the past 12 months has any applicant used any tobacco products?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. <b>Has any applicant taken any prescription medications during the past 6 months?</b>				Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>If yes, complete medication chart below:</b>					
<b>Name</b>	<b>Medication</b>	<b>Reason Prescribed</b>	<b>Name, Address of Doctor</b>		

<b>(D) Applicant(s) Coverage Information:</b>	
1. Will any existing in force hospital, medical, or major medical insurance be replaced or changed if the proposed coverage is issued? (If "YES," please complete the Replacement Form)	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "Yes," For Which Applicant? _____	
For Which Company? _____	

## 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 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 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 MIB. I (We) authorize the Company, or its reinsurers, to make a brief report of my (our) personal health information to MIB. This Authorization includes all information about drugs, alcoholism, and mental illness. I (We) understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. Although federal regulations require that the Company inform Me (Us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. I (We) agree that this Authorization will be valid for 24 months from the date signed, and know that I (We) or my (our) authorized representative may have a photocopy of it.

I (We) have received an Outline of Coverage. If this application is completed electronically, I (We) understand the Outline of Coverage will be delivered electronically or with the policy. If the application is completed over the phone the Outline of Coverage will be delivered with the policy. 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 State

\_\_\_\_\_  
Applicant # 1 Signature

\_\_\_\_\_  
Applicant #2 Signature (if applicable)

**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)	E-mail Address	Agent Code
Agent's Signature		Date

APPH9-11

**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
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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 agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

\_\_\_\_\_  
Printed name of insured if different from premium payer

\_\_\_\_\_  
Premium payer's signature, as it appears on bank records

**NOTICE TO APPLICANT – PARTS 1 AND 2**

**Part 1: Fair Credit Reporting Act and Privacy Act Pre-Notification**

The application you completed for insurance with us, in most cases, gives us all the information we need. In certain cases, we may need more information.

If we need more information, we may get it by talking to other persons you know including, but not limited to, your agent or other insurance companies you have applied to. We may ask an independent “consumer reporting agency” to help us verify facts or get additional facts.

We may collect information concerning your health, job and financial situation, as well as your character, general reputation and mode of living. We will not collect information relating to your sexual orientation.

The personal information we obtain about you is treated as confidential and will not be discussed to other persons or organizations without your written authorization except to the extent necessary as permitted by law, for the conduct of our business. But any information collected by a “consumer reporting agency” may be shared by the agency with others who use such information, but only to the extent which the Fair Credit Reporting Act Permits. You have a right of access, and right of correction, concerning recorded personal information obtained in our file. In order to exercise these rights, you must contact us in writing requesting access or correction.

You have no access right to privileged information. If we used a “consumer reporting agency,” you have the right to: (1) ask to talk with them and (2) ask them about their report. You may write us for the name and address of the agency. This paragraph is not intended as a complete description of your right of access and correction. If you would like a more complete description of our Insurance Information and Privacy Protection Practices, please write: Guarantee Trust Life Insurance Company, 1275 Milwaukee Avenue Glenview, IL 60025.

**Part 2: Notification Regarding 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 MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB, Inc.'s file, you may contact the MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address to the MIB information office is 50 Braintree Hill Park, Suite 400, Braintree Massachusetts 02184-8734, telephone number (866) 692-6901, e-mail address infoline@mib.com. Guarantee Trust Life Insurance Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

**RECEIPT**

**DATE** \_\_\_\_\_

Received of \_\_\_\_\_ the sum of \$ \_\_\_\_\_ and application for insurance to Guarantee Trust Life Insurance Company. If for any reason the application is declined this payment will be refunded. No liability is created or assumed by the Company, except for refund of this payment, until the insurance applied for has been issued.

Agent's Signature: \_\_\_\_\_

If you do not receive your policy/certificate within 60 days from the date of your application, please write to:

Guarantee Trust Life Insurance Company, 1275 Milwaukee Avenue Glenview, IL 60025

**MAKE CHECK PAYABLE TO: GUARANTEE TRUST LIFE INSURANCE COMPANY**

**GUARANTEE TRUST LIFE INSURANCE COMPANY**  
1275 MILWAUKEE AVENUE, GLENVIEW, IL 60025  
(800) 338-7452

**SHORT-TERM NURSING HOME CARE  
INDEMNITY INSURANCE POLICY  
OUTLINE OF COVERAGE**

For Policy Form G1181  
[With Optional Rider Forms RG11HHC, RG11IPB and RG11IPG]

**CAUTION:** The policy was issued based on your answers to the questions on your Application. A copy of your Application will be attached to your policy. If your answers are incorrect or untrue, we may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us within 30 days at 1275 Milwaukee, Glenview, Illinois 60025.

If you have any questions concerning this coverage, or if we can be of any assistance, please call us at  
**1-800-338-7452**

**NOTICE TO BUYER**

THE POLICY MAY NOT COVER ALL OF THE COSTS ASSOCIATED WITH SHORT-TERM NURSING HOME CARE INCURRED BY THE BUYER DURING THE PERIOD OF COVERAGE. THIS IS A LIMITED POLICY. THE BUYER IS ADVISED TO REVIEW CAREFULLY ALL POLICY LIMITATIONS AND EXCEPTIONS.

**POLICY DESIGNATION**

The policy is an individual policy of insurance.

**PURPOSE OF OUTLINE OF COVERAGE**

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

**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 premium 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**. We may change your premium by giving you at least thirty-one (31) days prior written notice. We can only do this when we change the premiums for all policies of this class in the state where you live.

**TERMS UNDER WHICH THIS POLICY MAY BE RETURNED AND PREMIUM REFUNDED**

First 30 days: If you return the policy to us or to our agent to be canceled within 30 days of receiving it, we will pay you all premium paid for the policy. After the policy has been returned it will be considered to have never been issued.

After the first 30 days: You may still terminate this coverage if you send written notice. We will end the coverage effective upon receipt or on a later date if specified in the notice. The termination will not affect any claim which was covered prior to the effective date of termination.

In the event of your death, we will refund any premium paid for a period beyond the date of your death.

**THIS IS NOT MEDICARE SUPPLEMENT COVERAGE**

If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from us. Neither Guarantee Trust Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

**LIMITED BENEFIT HEALTH INSURANCE COVERAGE**

Policies of this category are designed to provide persons insured with limited or supplemental coverage.

The policy provides coverage on an indemnity basis for covered short-term nursing home and assisted living facility care. All benefits are subject to the limitations and exceptions described in the policy.

**BENEFITS PROVIDED BY THE POLICY**

Elimination Period \_\_\_\_\_ days

Benefit Period \_\_\_\_\_ days

Daily Benefit Amount \$ \_\_\_\_\_

**QUALIFYING FOR BENEFITS AND BENEFIT LIMITATIONS**

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**A. QUALIFYING FOR BENEFITS**

Before benefits will be payable for Covered Care:

1. a Licensed Health Care Practitioner must certify that the services received for Covered Care available under this policy are needed pursuant to a Plan of Care;
2. You have a Functional Disability; and
3. You satisfy the Elimination Period, if any.

We may periodically review the necessity of care and treatment. Our review, for example, may include: (a) diagnosis, symptoms, complaints, and complications of a condition; (b) the reason for the services being rendered; (c) a Licensed Health Care Practitioner’s orders; (d) schedule of treatment; (e) physical limitations and impairments; and (f) the objectives of the Licensed Health Care Practitioner’s Plan of Care.

**B. LIMITATION ON BENEFITS**

Subject to the Qualifying For Benefits and Benefit Limitations provision, we’ll pay the Daily Benefit Amount for all Covered Care available under this policy. We’ll pay for such Covered Care received during Any One Period of Care.

We won’t pay more than the number of Benefit Period days, as shown in the policy schedule, during Any One Period of Care for all benefits available under this policy. Any One Period of Care can only be restored once during the life of the policy. Any days which remain unpaid during Any One Period of Care cannot be carried forward and added to the Benefit Period of the next Any One Period of Care.

We won’t pay benefits for more days than are available under the Maximum Benefit Period during the life of the policy.

Covered Care is incurred on the date the service or treatment is given or the supply is bought. Covered Care must be incurred while this coverage is in force.

**C. COVERED CARE MEANS:**

1. Nursing Home Care:  
The care (including room, board, services and supplies) provided for each day of care during a Nursing Home stay for all levels of care (skilled, intermediate, or custodial).

2. Assisted Living Facility Care  
  
The care (including room, board, services and supplies) provided during a stay in an Assisted Living Facility.

We will only pay one Daily Benefit Amount on any day You incur Nursing Home Care and Assisted Living Facility Care on the same day.

**DEFINITIONS**

**Activities of Daily Living** means the following (6) basic activities of daily living:

1. **Bathing** means washing oneself by sponge bath in either a tub or shower, including the task of getting into or out of the tub or shower.
2. **Continence** means the ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
3. **Dressing** means the ability to put on or take off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. **Eating** means the ability to feed oneself by getting food into the body from a receptacle (e.g., plate, cup, table) or by a feeding tube or intravenously.
5. **Toileting** means the ability to get to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. **Transferring** means the ability to move into or out of a bed, chair or wheelchair without assistance.

**Cognitive Impairment** means a deterioration or loss in intellectual capacity which requires Substantial Supervision to protect oneself from threats to health and safety. Cognitive Impairment is measured by clinical evidence and standardized tests that reliably measure impairment in one's: (1) short or long-term memory; (2) orientation as to people, places, or time; and (3) deductive or abstract reasoning.

Such loss of intellectual capacity can result from the following covered conditions: Alzheimer's Disease, Parkinson's Disease, senile dementia or other nervous or mental disorders of organic origin.

**Functionally Disabled/Functional Disability** means an Insured who is:

1. unable to perform at least 2 Activities of Daily Living without human assistance or supervision; or
2. requires Substantial Supervision to protect such individual from threats to health and safety due to Cognitive Impairment.

## **EXCEPTIONS**

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We won't pay for treatment, care, services or supplies which are:

1. due to war or act of war whether declared or not;
2. due to intentionally self-inflicted Injury while sane or insane;
3. for services or supplies provided by a member of the Immediate Family; an individual who normally resides with you on a regular basis; or in a facility owned or operated by a member of the Immediate Family;
4. for services and supplies not included in your Plan of Care;
5. for which no charge is customarily made in the absence of insurance;
6. for care received outside the United States or its territories; or
7. for alcoholism, drug addiction, or chemical dependency, unless as a result of a medication prescribed by a Doctor.

## **PRE-EXISTING CONDITION LIMITATION**

Coverage under the Policy is subject to a pre-existing conditions limitation. Pre-existing conditions are those medical conditions disclosed or not disclosed on the application for which medical advice or treatment was recommended or received from a Doctor within 6 months prior to the Effective Date of your coverage.

Any loss due to a pre-existing condition isn't covered unless the loss begins more than 6 months after the Effective Date of coverage.

## **THE POLICY MAY NOT COVER ALL OF THE EXPENSES ASSOCIATED WITH YOUR NURSING HOME NEEDS**

### **RELATIONSHIP OF COST OF CARE AND BENEFITS.**

Because the costs of nursing home services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. Your benefits will not increase unless you elect one of the optional Inflation Protection Benefit Riders. There is an additional premium for this option.

**DENIAL OF APPLICATION.**

Guarantee Trust Life Insurance will refund any premiums within 30 days of denial of an application.

**[OPTIONAL SHORT-TERM HOME HEALTH CARE INSURANCE RIDER**

Before Home Health Care benefits will be payable for an Insured's Covered Home Care:

1. a Licensed Health Care Practitioner must certify that the Home Health Care services are needed because the Insured has a Functional Disability as defined within this rider; and
2. Home Health Care services are provided pursuant to a Plan of Care; and
3. You satisfy the Elimination Period, if any.

**Functionally Disabled/Functional Disability** means an Insured who:

1. is unable to perform at least 2 Activities of Daily Living without human assistance or supervision; or
2. requires Substantial Supervision to protect such individual from threats to health and safety due to Cognitive Impairment.

**Home Health Care** means medical and non-medical services provided by a Home Health Care Practitioner in your Home.

**Home Health Care Practitioner** means an individual who is qualified to provide Home Health Care. A Home Health Care Practitioner includes the following: a home health aide; a provider of medical or social services; a registered professional nurse (RN); a licensed practical nurse (LPN); a licensed vocational nurse (LVN); a licensed speech therapist or audiologist; a licensed respiratory therapist; a licensed physical therapist; a licensed chemotherapy specialist; or a licensed nutritional therapist. A Home Health Care Practitioner whose specialty is not listed here may be used if approved by us prior to the practitioner providing the service. A Home Health Care Practitioner:

1. must be licensed in the state, or recognized as such by the state in which the care is given;
2. may not be an Insured;
3. may not reside at your address;
4. must present a charge for the care given which you are legally obligated to pay; and
5. must be employed or contracted by a Home Health Care Agency.

**BENEFITS PROVIDED BY THE HOME HEALTH CARE RIDER**

Home Health Care Elimination Period \_\_\_\_\_ days  
 Home Health Care Daily Benefit Amount \_\_\_\_\_ per visit  
 Home Health Care Benefit Maximum \_\_\_\_\_ visits

Adding this benefit to your policy will increase your policy premium by \_\_\_\_\_.]

**[OPTIONAL SIMPLE INCREASING INFLATION PROTECTION BENEFIT RIDER**

We will increase your initial Daily Benefit Amount by 5% on each policy anniversary. The initial Daily Benefit Amount and the Inflation Period are shown on the Policy Schedule. Each 5 percent increase will be added to the Daily Benefit Amount then in effect.

Adding this benefit to your policy will increase your policy premium by \_\_\_\_\_.]

**[OPTIONAL COMPOUND INCREASING INFLATION PROTECTION BENEFIT RIDER**

One year after this rider's Effective Date, provided the policy to which it is attached is in force, we will increase your initial Daily Benefit Amount for Any One Period of Care by 5%. (The Daily Benefit Amount for Any One Period of Care is shown on the Policy Schedule.) On each subsequent policy anniversary, we will continue to increase your current Daily Benefit Amount for Any One Period of Care (which includes prior year(s) increases) by 5%. These increases will continue to take place on each policy anniversary for the Inflation Period specified on the Policy Schedule. The increases occur whether or not you are receiving benefits under the policy.

Adding this benefit to your policy will increase your policy premium by \_\_\_\_\_.]

**THIS SHORT-TERM NURSING HOME CARE INDEMNITY INSURANCE POLICY DOES NOT QUALIFY THE INSURED FOR THE FAVORABLE TAX TREATMENT PROVIDED FOR IN THE INTERNAL REVENUE CODE OF 1986, SECTION 7702(B) AS ENACTED BY “THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT” OF 1996.**

**GUARANTEED RENEWABLE FOR LIFE** You may keep this Policy, and Riders if attached, in force during Your entire lifetime, unless otherwise stated in the Rider, by paying the renewal premium at the intervals available to You at time of renewal. You must pay the renewal premium by its due date or during the 31 days that follow. We cannot cancel or refuse to renew this Policy or place any restrictions on it if You pay Your premiums on time.

**PREMIUMS SUBJECT TO CHANGE** We may change the premium rates for this Policy/Riders by giving You at least 31 days prior written notice of any change in the renewal premium. We can only change the premium if We change it for all Policies/Riders like Yours in Your state on a class basis.

**PREMIUM.**

Total **annual** policy premium for coverage that You applied for is:

**COVERAGE**

Policy	\$_____
[Optional Home Health Care Rider	\$_____]
[Optional Inflation Protection Benefit Rider	\$_____]
TOTAL \$_____	

*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**

1275 Milwaukee Avenue, Glenview, IL 60025  
(847) 699-0600

**SHORT-TERM HOME HEALTH CARE INSURANCE RIDER**

**RIDER EFFECTIVE DATE:** \_\_\_\_\_

This rider is a part of the policy to which it's attached. It takes effect on the Effective Date shown above at 12:01 a.m. Standard Time where you live. If no date is shown, it begins on the policy's Effective Date. The policy premium shown on the schedule includes the additional premium for this rider.

**WE PROMISE** to insure you for the benefits described in this rider. We make this promise in consideration of the application for this rider and payment of the premium. The application for this rider is a part of the policy.

**RIGHT TO EXAMINE RIDER:** If you are not satisfied with this rider for any reason, you may return it to us within thirty (30) days of its receipt. Upon return, we will void this rider as of its Effective Date and you will receive a full refund of any premium you have paid.

**RENEWAL CONDITIONS:** This rider is renewed when the policy to which it's attached is renewed. This rider ends when the policy to which it's attached ends. We can change the premium for this rider if we change it for all riders like yours in your state on a class basis. We'll tell you in advance of any change in the premium.

**PREMIUMS:** The policy premium shown on the schedule includes the additional premium for this rider.

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



Secretary



President

## RIDER DEFINITIONS

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**Functionally Disabled/Functional Disability** means an Insured who is:

1. unable to perform at least 2 Activities of Daily Living without human assistance or supervision; or
2. requires Substantial Supervision to protect such individual from threats to health and safety due to Cognitive Impairment.

**Home** means the place where you normally live. It includes a private dwelling, a home for the retired or aged, or a facility providing residential care. It does not include a hospital, sanitarium or Nursing Home.

**Home Health Care** means medical and non-medical services provided by a Home Health Care Practitioner in your Home.

**Home Health Care Agency** means an agency or organization which specializes in giving nursing care or therapeutic services in the home, while maintaining a complete medical record and Plan of Care for each patient and which:

1. is licensed to provide such care or services by the appropriate licensing agency where they are performed or is certified as a Home Health Care Agency under Title XVII of the Social Security Act of 1965, as amended; and
2. is operating within the scope of its license or certification

Home Health Care Agency does not mean any other similar service or agency which does not meet this definition, even if the service or agency meets some of the above requirements or provides some or all of the services which may be provided by a Home Health Care Agency.

**Home Health Care Practitioner** means an individual who is qualified to provide Home Health Care. A Home Health Care Practitioner includes the following: a home health aide; a provider of medical or social services; a registered professional nurse (RN); a licensed practical nurse (LPN); a licensed vocational nurse (LVN); a licensed speech therapist or audiologist; a licensed respiratory therapist; a licensed physical therapist; a licensed chemotherapy specialist; or a licensed nutritional therapist. A Home Health Care Practitioner whose specialty is not listed here may be used if approved by us prior to the practitioner providing the service. A Home Health Care Practitioner:

1. must be licensed in the state, or recognized as such by the state in which the care is given;
2. may not be an Insured;
3. may not reside at your address;
4. must present a charge for the care given which you are legally obligated to pay; and
5. must be employed or contracted by a Home Health Care Agency.

**Home Health Care Benefit Maximum** means the maximum number of visits for which we will provide benefits under the Home Health Care Daily Benefit Amount. The Home Health Care Benefit Maximum is shown in the policy schedule.

**Home Health Care Daily Benefit Amount** means the maximum amount we will pay you per visit for covered Home Health Care charges. The Home Health Care Daily Benefit Amount is shown in the policy schedule.

**Home Health Care Elimination Period** means the number of days for which no benefits are payable under this rider. The Home Health Care Elimination Period must be satisfied once during the life of the rider and can only be satisfied by days on which you incur Covered Home Care for which payment would be made under this rider if there were no Elimination Period. The Home Health Care Elimination Period applies to days on which you incur charges for Home Health Care services. The Home Health Care Elimination Period is shown on the policy schedule.

## BENEFIT PROVISIONS

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### A. QUALIFYING FOR BENEFITS

Before Home Health Care benefits will be payable for an Insured's Covered Home Care:

1. a Licensed Health Care Practitioner must certify that the Home Health Care services are needed because the Insured has a Functional Disability as defined within this rider; and
2. the Home Health Care Elimination Period, if any, must be satisfied. The Home Health Care Elimination Period is shown on the policy schedule.

We may periodically review the necessity of care and treatment. Our review, for example, may include but is not limited to: (a) diagnosis, symptoms, complaints, and complications of a condition; (b) the reason for the services being rendered; (c) a Licensed Health Care Practitioner's orders; (d) schedule of treatment; (e) physical limitations and impairments; and (f) the objectives of the Licensed Health Care Practitioner's Plan of Care, as defined within the Policy to which this rider is attached.

### B. LIMITATION ON BENEFITS

Subject to the qualifying for benefits provision above, we'll pay the Home Health Care Daily Benefit Amount, up to the Home Health Care Benefit Maximum for all Covered Home Care available under this rider.

We won't pay more than the Home Health Care Benefit Maximum during the life of this rider.

Benefits under this rider will not be provided for any day where benefits are payable under Your Policy.

Covered Home Care is incurred on the date the service or treatment is given or the supply is bought. Covered Home Care must be incurred while this coverage is in force.

### C. COVERED HOME CARE MEANS:

1. Home Health Care:

The care (medical and non-medical services) provided by a Home Health Care Practitioner in your Home.

Home Health Care does not mean care rendered by a member of your Immediate Family.

We won't pay for more than one Home Health Care visit per day.

**CONDITIONS:** This rider is subject to all terms, provisions, limitations and exceptions of the policy except where changed by this rider.

**GUARANTEE TRUST LIFE INSURANCE COMPANY**

1275 Milwaukee Avenue, Glenview, IL 60025

(847) 699-0600

**SIMPLE INCREASING INFLATION PROTECTION BENEFIT RIDER**

**RIDER EFFECTIVE DATE:** \_\_\_\_\_

This rider is a part of the policy to which it's attached. It takes effect on the Effective Date shown above at 12:01 a.m. Standard Time where you live. If no date is shown, it begins on the policy's Effective Date.

**YOUR THIRTY DAY RIGHT TO RETURN THIS RIDER**

If you are not satisfied with this rider, you may return it to us within 30 days of its receipt. We'll then refund all premiums paid for this rider and it will be void.

**RIDER DEFINITIONS**

**"Inflation Period"** means the number of years or duration of time we will continue to increase benefit amounts under the terms of this rider.

**BENEFITS**

After this rider's effective date, provided the policy to which this rider is attached is in force, we will increase your initial Daily Benefit Amount by 5 percent on each policy anniversary. The initial Daily Benefit Amount and the Inflation Period are shown on the schedule. The 5 percent increase will be added to the then current Daily Benefit Amount.

During Any One Period of Care, the Daily Benefit Amount that will be payable will be such increased amount that was in effect at the time the loss was incurred.

This rider does not apply to any added benefit rider attached to the policy.

**RENEWAL CONDITIONS**

This rider is renewed when the policy to which it is attached is renewed. This rider ends when the policy to which it is attached ends.

**PREMIUM**

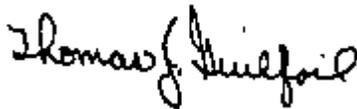
This rider requires the payment of premium in addition to the premium due for the policy. The premium shown in the policy schedule includes the additional premium for this rider.

We can change the premium for this rider if we change it for all riders like yours in your state on a class basis. We'll provide you with written notice of any change in the premium in the time required by your state.

**CONDITIONS**

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

Signed for the 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

**COMPOUND INCREASING INFLATION PROTECTION BENEFIT RIDER**

**RIDER EFFECTIVE DATE:** \_\_\_\_\_

This rider is a part of the policy to which it is attached. 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.

**YOUR THIRTY DAY RIGHT TO RETURN THIS RIDER**

If you are not satisfied with this rider, you may return it to us within 30 days of its receipt. We'll then refund all premiums paid for this rider and it will be void.

**RIDER DEFINITIONS**

**"Inflation Period"** means the number of years or duration of time we will continue to increase benefit amounts under the terms of this rider.

**BENEFITS**

One year after this rider's Effective Date, provided the policy to which it is attached is in force, we will increase your initial Daily Benefit Amount for Any One Period of Care by 5%. (The Daily Benefit Amount for Any One Period of Care is shown on the policy schedule.) On each subsequent policy anniversary, we will continue to increase your current Daily Benefit Amount for Any One Period of Care (which are inclusive of prior year(s) increases) by 5%. These increases will continue to take place on each policy anniversary for the Inflation Period specified on the policy schedule. The increases are without regard to whether or not you are receiving benefits under the policy.

During Any One Period of Care, the Daily Benefit Amount that will be payable will be such increased amount that was in effect at the time the loss was incurred.

This rider does not apply to any added benefit rider attached to the policy.

**RENEWAL CONDITIONS**

This rider is renewed when the policy to which it is attached is renewed. This rider ends when the policy to which it is attached ends.

**PREMIUM**

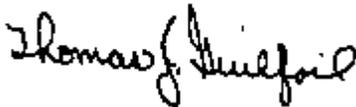
This rider requires the payment of premium in addition to the premium due for the policy. The premium for this benefit rider is shown on the policy schedule.

We can change the premium for this rider if we change it for all riders like yours in your state on a class basis. We'll provide you with written notice of any change in the premium in the time required by your state.

**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

SERFF Tracking Number: GRTT-128519381 State: Arkansas  
 Filing Company: Guarantee Trust Life Insurance Company State Tracking Number:  
 Company Tracking Number: G1181  
 TOI: H131 Individual Health - Short Term Care Sub-TOI: H131.002 Nursing Home  
 Product Name: Recovery Care  
 Project Name/Number: Recovery Care/G1181

**Rate Information**

Rate data applies to filing.

**Filing Method:**

**Rate Change Type:** %

**Overall Percentage of Last Rate Revision:** %

**Effective Date of Last Rate Revision:**

**Filing Method of Last Filing:**

**Company Rate Information**

Company Name:	Overall % Indicated Change:	Overall % Rate Impact:	Written Premium Change for this Program:	# of Policy Holders Affected for this Program:	Written Premium for this Program:	Maximum % Change (where required):	Minimum % Change (where required):
Guarantee Trust Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking Number: GRTT-128519381 State: Arkansas  
 Filing Company: Guarantee Trust Life Insurance Company State Tracking Number:  
 Company Tracking Number: G1181  
 TOI: H131 Individual Health - Short Term Care Sub-TOI: H131.002 Nursing Home  
 Product Name: Recovery Care  
 Project Name/Number: Recovery Care/G1181

## Rate/Rule Schedule

Schedule Item Status:	Document Name:	Affected Form Numbers: (Separated with commas)	Rate Action:	Rate Action Information:	Attachments
Approved-Closed 06/27/2012	Actuarial Memorandum	G1181-AR, APPH9-11, OCG1181, RG11HHC, RG11IPB, RG11IPG	New		STC Actuarial Memorandum.pdf
Approved-Closed 06/27/2012	Rates	G1181-AR, APPH9-11, OCG1181, RG11HHC, RG11IPB, RG11IPG	New		Premium_Rates_Filing.pdf
Approved-Closed 06/27/2012	Loss Ratio Exhibit	G1181-AR, APPH9-11, OCG1181, RG11HHC, RG11IPB, RG11IPG	New		Exhibit 3 - Loss Ratio Exhibit.pdf

**Guarantee Trust Life Insurance Company**  
**Short Term Care Product - Policy Form G1181-Series**  
**Single Insured Premium Rates Per \$10 A Day**

Annual Non-Tobacco Rates							Annual Non-Tobacco Rates						
Issue Age	0 Day EP 30 Day BP	0 Day EP 45 Day BP	0 Day EP 60 Day BP	0 Day EP 90 Day BP	0 Day EP 180 Day BP	0 Day EP 360 Day BP	Issue Age	20 Day EP 30 Day BP	20 Day EP 45 Day BP	20 Day EP 60 Day BP	20 Day EP 90 Day BP	20 Day EP 180 Day BP	20 Day EP 360 Day BP
40-50	3.00	4.00	4.90	6.80	14.10	22.70	40-50	2.50	3.40	4.10	5.70	12.70	20.40
51	3.40	4.40	5.45	7.55	14.10	22.70	51	2.90	3.70	4.60	6.35	12.70	20.40
52	3.80	4.80	6.00	8.30	14.10	22.70	52	3.20	4.00	5.10	7.00	12.70	20.40
53	4.00	4.90	6.20	8.60	14.60	23.60	53	3.40	4.20	5.30	7.30	13.20	21.20
54	4.10	5.10	6.40	8.90	15.10	24.60	54	3.50	4.40	5.50	7.60	13.70	22.10
55	4.20	5.30	6.60	9.20	15.70	25.60	55	3.60	4.60	5.70	7.90	14.20	23.00
56	4.30	5.50	6.80	9.50	16.30	26.60	56	3.70	4.70	5.90	8.20	14.70	24.00
57	4.40	5.70	7.00	9.80	16.90	27.70	57	3.80	4.90	6.10	8.50	15.20	25.00
58	4.70	6.10	7.60	10.60	18.30	29.80	58	4.10	5.30	6.60	9.20	16.40	27.00
59	5.10	6.60	8.20	11.40	19.70	32.20	59	4.40	5.70	7.10	9.90	17.70	29.20
60	5.50	7.10	8.90	12.30	21.20	34.80	60	4.80	6.20	7.70	10.70	19.10	31.50
61	5.90	7.70	9.60	13.30	22.80	37.60	61	5.10	6.70	8.40	11.60	20.60	34.00
62	6.30	8.30	10.40	14.30	24.60	40.60	62	5.50	7.30	9.10	12.50	22.20	36.70
63	6.90	9.10	11.40	15.70	27.00	44.70	63	6.00	7.90	9.90	13.70	24.40	40.30
64	7.60	10.00	12.50	17.20	29.70	49.10	64	6.70	8.80	11.00	15.10	26.80	44.30
65	8.30	11.00	13.70	18.90	32.70	53.90	65	7.30	9.70	12.00	16.60	29.40	48.70
66	9.10	12.10	15.00	20.70	36.00	59.20	66	8.00	10.60	13.20	18.20	32.30	53.50
67	10.00	13.30	16.50	22.70	39.60	65.00	67	8.80	11.70	14.50	20.00	35.50	58.80
68	10.80	14.50	18.00	24.90	43.30	71.10	68	9.50	12.80	15.80	21.90	38.80	64.40
69	11.70	15.80	19.70	27.20	47.30	77.80	69	10.30	13.90	17.30	23.90	42.40	70.40
70	12.70	17.30	21.50	29.70	51.70	85.20	70	11.20	15.20	18.90	26.10	46.40	77.00
71	13.80	18.90	23.50	32.50	56.50	93.30	71	12.10	16.60	20.70	28.60	50.80	84.20
72	15.00	20.70	25.70	35.50	61.70	102.10	72	13.20	18.30	22.70	31.30	55.60	92.10
73	16.50	22.70	28.10	38.80	67.60	111.90	73	14.60	20.10	24.80	34.30	60.90	100.80
74	18.20	24.90	30.70	42.40	74.00	122.50	74	16.10	22.00	27.20	37.50	66.70	110.40
75	20.00	27.30	33.50	46.40	81.00	134.10	75	17.70	24.10	29.60	41.00	73.00	120.90
76	22.00	30.00	36.60	50.80	88.70	146.80	76	19.40	26.50	32.30	44.90	79.90	132.40
77	24.20	32.90	40.00	55.60	97.10	160.80	77	21.40	29.10	35.40	49.20	87.50	145.00
78	26.30	35.50	43.30	60.20	105.10	174.00	78	23.20	31.40	38.30	53.20	94.60	156.80
79	28.50	38.30	46.80	65.10	113.70	188.20	79	25.20	33.90	41.40	57.60	102.30	169.70
80	30.90	41.40	50.60	70.40	123.00	203.60	80	27.30	36.60	44.80	62.30	110.70	183.60
81	33.50	44.70	54.70	76.20	133.10	220.30	81	29.60	39.50	48.40	67.40	119.80	198.70
82	36.30	48.30	59.20	82.40	144.00	238.30	82	32.10	42.70	52.40	72.90	129.60	215.00
83	38.40	50.90	62.70	87.10	152.20	252.30	83	33.90	45.00	55.40	77.00	137.00	227.30
84	40.70	53.70	66.40	92.20	160.90	267.10	84	35.90	47.40	58.60	81.40	144.90	240.30

**Above Premium Rates do not include an annual policy fee of \$25.00**

**Additional Premium Rate Factors**

Spouse Discount Factor: 0.900  
 Tobacco Rate Up: 1.100

**Modal Factors**

Semi-Annual 0.5150  
 Quarterly 0.2600  
 Monthly (Direct Bill): 0.0900  
 Monthly (Bank Draft): 0.0840

**Guarantee Trust Life Insurance Company**  
**Short Term Care Product - Policy Form G1181-Series with 5% Simple Inflation Rider (RG11IPB-Series)**  
**Single Insured Premium Rates Per \$10 A Day**

Annual Non-Tobacco Rates with 5% Simple Inflation							Annual Non-Tobacco Rates with 5% Simple Inflation						
Issue Age	0 Day EP 30 Day BP	0 Day EP 45 Day BP	0 Day EP 60 Day BP	0 Day EP 90 Day BP	0 Day EP 180 Day BP	0 Day EP 360 Day BP	Issue Age	20 Day EP 30 Day BP	20 Day EP 45 Day BP	20 Day EP 60 Day BP	20 Day EP 90 Day BP	20 Day EP 180 Day BP	20 Day EP 360 Day BP
40-50	6.00	8.00	9.80	13.60	28.20	45.40	40-50	5.00	6.80	8.20	11.40	25.40	40.80
51	6.80	8.80	10.90	15.10	28.20	45.40	51	5.80	7.40	9.20	12.70	25.40	40.80
52	7.60	9.60	12.00	16.60	28.20	45.40	52	6.40	8.00	10.20	14.00	25.40	40.80
53	7.70	9.70	12.20	16.90	28.90	46.50	53	6.50	8.30	10.40	14.30	26.10	41.80
54	7.80	9.90	12.40	17.20	29.50	47.60	54	6.70	8.50	10.70	14.70	26.80	42.80
55	7.90	10.10	12.60	17.50	30.10	48.80	55	6.80	8.80	10.90	15.00	27.20	43.80
56	8.00	10.30	12.80	17.80	30.70	50.00	56	6.90	8.80	11.10	15.40	27.70	45.10
57	8.10	10.50	13.00	18.10	31.30	51.20	57	7.00	9.00	11.30	15.70	28.20	46.20
58	8.60	11.20	13.90	19.30	33.50	54.70	58	7.50	9.70	12.10	16.80	30.00	49.60
59	9.20	12.00	14.90	20.70	35.80	58.60	59	7.90	10.40	12.90	18.00	32.20	53.10
60	9.80	12.80	16.00	22.10	38.30	62.80	60	8.60	11.20	13.80	19.20	34.50	56.80
61	10.50	13.70	17.20	23.70	40.90	67.30	61	9.10	11.90	15.10	20.70	37.00	60.90
62	11.20	14.70	18.50	25.40	43.70	72.10	62	9.80	12.90	16.20	22.20	39.40	65.20
63	12.10	16.00	20.00	27.50	47.30	78.00	63	10.50	13.90	17.40	24.00	42.70	70.30
64	13.10	17.30	21.60	29.70	51.30	84.50	64	11.50	15.20	19.00	26.10	46.30	76.20
65	14.20	18.70	23.30	32.10	55.60	91.50	65	12.50	16.50	20.40	28.20	50.00	82.70
66	15.30	20.20	25.20	34.70	60.30	99.10	66	13.50	17.70	22.20	30.50	54.10	89.60
67	16.50	21.90	27.20	37.50	65.30	107.30	67	14.50	19.30	23.90	33.00	58.50	97.10
68	17.50	23.50	29.20	40.30	70.10	115.30	68	15.40	20.70	25.60	35.40	62.80	104.40
69	18.60	25.20	31.30	43.20	75.20	123.80	69	16.40	22.20	27.50	38.00	67.40	112.00
70	19.80	27.00	33.60	46.30	80.60	132.90	70	17.50	23.70	29.50	40.70	72.30	120.10
71	21.10	29.00	36.00	49.70	86.40	142.70	71	18.50	25.50	31.70	43.70	77.70	128.80
72	22.50	31.10	38.60	53.30	92.60	153.20	72	19.80	27.50	34.10	47.00	83.40	138.20
73	24.20	33.40	41.20	57.10	99.30	164.30	73	21.40	29.60	36.40	50.50	89.50	148.00
74	26.10	35.90	44.10	61.20	106.40	176.20	74	23.10	31.70	39.10	54.10	95.90	158.80
75	28.10	38.50	47.20	65.50	114.10	188.90	75	24.90	34.00	41.70	57.90	102.80	170.30
76	30.30	41.30	50.50	70.10	122.30	202.50	76	26.70	36.50	44.60	62.00	110.20	182.60
77	32.70	44.40	54.00	75.10	131.10	217.10	77	28.90	39.30	47.80	66.50	118.10	195.80
78	34.90	47.20	57.60	80.00	139.70	231.30	78	30.80	41.70	50.90	70.70	125.70	208.40
79	37.30	50.20	61.30	85.20	148.80	246.40	79	33.00	44.40	54.20	75.40	133.90	222.20
80	39.80	53.40	65.30	90.80	158.50	262.50	80	35.20	47.20	57.80	80.40	142.70	236.70
81	42.50	56.80	69.50	96.70	168.90	279.60	81	37.60	50.20	61.50	85.50	152.00	252.20
82	45.40	60.40	74.00	103.00	180.00	297.90	82	40.10	53.40	65.50	91.10	162.00	268.80
83	48.00	63.60	78.40	108.90	190.30	315.40	83	42.40	56.20	69.30	96.30	171.30	284.10
84	50.90	67.10	83.00	115.30	201.10	333.90	84	44.90	59.20	73.30	101.80	181.10	300.40

**Above Premium Rates do not include an annual policy fee of \$25.00**

**Additional Premium Rate Factors**

Spouse Discount Factor: 0.900  
 Tobacco Rate Up: 1.100

**Modal Factors**

Semi-Annual 0.5150  
 Quarterly 0.2600  
 Monthly (Direct Bill): 0.0900  
 Monthly (Bank Draft): 0.0840

**Guarantee Trust Life Insurance Company**  
**Short Term Care Product - Policy Form G1181-Series with 5% Compound Inflation Rider (RG11IPG-Series)**  
**Single Insured Premium Rates Per \$10 A Day**

Annual Non-Tobacco Rates with 5% Compound Inflation							Annual Non-Tobacco Rates with 5% Compound Inflation						
Issue Age	0 Day EP 30 Day BP	0 Day EP 45 Day BP	0 Day EP 60 Day BP	0 Day EP 90 Day BP	0 Day EP 180 Day BP	0 Day EP 360 Day BP	Issue Age	20 Day EP 30 Day BP	20 Day EP 45 Day BP	20 Day EP 60 Day BP	20 Day EP 90 Day BP	20 Day EP 180 Day BP	20 Day EP 360 Day BP
40-50	8.40	11.20	13.70	19.00	39.50	63.60	40-50	7.00	9.50	11.50	15.90	35.60	57.20
51	9.50	12.30	15.25	21.10	39.50	63.60	51	8.10	10.30	12.90	17.70	35.60	57.20
52	10.60	13.40	16.80	23.20	39.50	63.60	52	8.90	11.20	14.30	19.60	35.60	57.20
53	10.60	13.60	17.00	23.60	40.30	65.20	53	9.00	11.70	14.50	20.00	36.40	58.60
54	10.80	13.90	17.30	24.00	41.20	66.80	54	9.20	12.00	14.90	20.50	37.40	60.00
55	11.00	14.20	17.60	24.50	42.10	68.50	55	9.40	12.30	15.20	21.00	38.10	61.50
56	11.20	14.50	17.90	25.00	43.00	70.20	56	9.60	12.40	15.50	21.60	38.80	63.30
57	11.40	14.80	18.20	25.50	43.90	72.00	57	9.80	12.70	15.90	22.10	39.50	65.00
58	12.10	15.80	19.40	27.20	46.70	76.90	58	10.60	13.70	16.80	23.60	41.90	69.70
59	12.90	16.80	20.80	29.00	49.80	82.00	59	11.10	14.50	18.00	25.20	44.70	74.40
60	13.70	17.90	22.20	30.90	53.10	87.50	60	12.00	15.60	19.20	26.90	47.80	79.20
61	14.50	19.10	23.80	32.90	56.60	93.30	61	12.50	16.60	20.80	28.70	51.10	84.40
62	15.40	20.30	25.50	35.00	60.30	99.50	62	13.40	17.90	22.30	30.60	54.40	89.90
63	16.30	21.50	26.90	37.00	64.00	105.50	63	14.20	18.70	23.40	32.30	57.80	95.10
64	17.30	22.80	28.50	39.20	67.90	111.90	64	15.30	20.10	25.10	34.40	61.30	101.00
65	18.30	24.20	30.20	41.50	72.10	118.60	65	16.10	21.30	26.50	36.40	64.80	107.20
66	19.40	25.70	31.90	43.90	76.50	125.70	66	17.10	22.50	28.10	38.60	68.60	113.60
67	20.50	27.30	33.80	46.50	81.20	133.30	67	18.00	24.00	29.70	41.00	72.80	120.60
68	21.50	28.70	35.70	49.10	85.70	141.00	68	18.90	25.30	31.30	43.20	76.80	127.70
69	22.50	30.30	37.70	51.90	90.50	149.10	69	19.80	26.70	33.10	45.60	81.10	134.90
70	23.60	32.00	39.80	54.80	95.50	157.60	70	20.80	28.10	35.00	48.20	85.70	142.40
71	24.70	33.80	42.00	57.90	100.80	166.60	71	21.70	29.70	37.00	51.00	90.60	150.40
72	25.90	35.70	44.30	61.20	106.40	176.10	72	22.80	31.60	39.10	54.00	95.90	158.90
73	27.60	37.90	46.90	64.90	112.90	186.90	73	24.40	33.60	41.40	57.40	101.70	168.40
74	29.40	40.30	49.70	68.80	119.80	198.40	74	26.00	35.60	44.00	60.80	108.00	178.80
75	31.40	42.90	52.60	72.90	127.10	210.60	75	27.80	37.90	46.50	64.40	114.50	189.90
76	33.50	45.60	55.70	77.30	134.90	223.50	76	29.50	40.30	49.20	68.30	121.50	201.60
77	35.70	48.50	59.00	82.00	143.20	237.20	77	31.60	42.90	52.20	72.60	129.00	213.90
78	37.70	50.90	62.00	86.20	150.40	249.20	78	33.30	45.00	54.80	76.20	135.40	224.60
79	39.70	53.40	65.10	90.60	158.10	261.80	79	35.10	47.30	57.60	80.20	142.20	236.10
80	41.80	56.00	68.40	95.20	166.20	275.10	80	36.90	49.50	60.60	84.20	149.60	248.10
81	44.00	58.70	71.90	100.00	174.70	289.10	81	38.90	51.90	63.60	88.50	157.20	260.80
82	46.30	61.60	75.50	105.10	183.60	303.80	82	40.90	54.50	66.80	93.00	165.20	274.10
83	48.80	64.60	79.60	110.60	193.30	320.40	83	43.10	57.10	70.30	97.80	174.00	288.70
84	51.70	68.20	84.30	117.10	204.30	339.20	84	45.60	60.20	74.40	103.40	184.00	305.20

**Above Premium Rates do not include an annual policy fee of \$25.00**

**Additional Premium Rate Factors**

Spouse Discount Factor: 0.900  
 Tobacco Rate Up: 1.100

**Modal Factors**

Semi-Annual 0.5150  
 Quarterly 0.2600  
 Monthly (Direct Bill): 0.0900  
 Monthly (Bank Draft): 0.0840

**Guarantee Trust Life Insurance Company**  
**Short Term Care Product - Home Health Care Rider RG11HC - Series**  
**Single Insured Premium Rates**

<b>\$25 Per Visit, Annual Non-Tobacco Rates</b>					<b>\$50 Per Visit, Annual Non-Tobacco Rates</b>					<b>\$75 Per Visit, Annual Non-Tobacco Rates</b>				
<b>Issue Age</b>	<b>0 Day EP 90 Visits</b>	<b>0 Day EP 180 Visits</b>	<b>20 Day EP 90 Visits</b>	<b>20 Day EP 180 Visits</b>	<b>Issue Age</b>	<b>0 Day EP 90 Visits</b>	<b>0 Day EP 180 Visits</b>	<b>20 Day EP 90 Visits</b>	<b>20 Day EP 180 Visits</b>	<b>Issue Age</b>	<b>0 Day EP 90 Visits</b>	<b>0 Day EP 180 Visits</b>	<b>20 Day EP 90 Visits</b>	<b>20 Day EP 180 Visits</b>
40-50	12.30	18.00	11.00	18.00	40-50	24.70	40.00	22.00	36.00	18-50	37.00	60.00	33.00	54.00
51	12.30	20.00	11.00	18.00	51	24.70	40.00	22.00	36.00	51	37.00	60.00	33.00	54.00
52	12.30	20.00	11.00	18.00	52	24.70	40.00	22.00	36.00	52	37.00	60.00	33.00	54.00
53	13.00	21.20	11.70	19.20	53	26.10	42.30	23.30	38.30	53	39.10	63.50	34.90	57.60
54	13.80	22.50	12.40	20.50	54	27.60	44.80	24.70	40.80	54	41.40	67.30	37.00	61.30
55	14.60	23.80	13.10	21.80	55	29.20	47.50	26.20	43.50	55	43.80	71.30	39.20	65.30
56	15.40	25.20	13.90	23.20	56	30.90	50.30	27.70	46.30	56	46.30	75.50	41.50	69.50
57	16.30	26.70	14.70	24.70	57	32.70	53.30	29.30	49.30	57	49.00	80.00	44.00	74.00
58	17.50	28.70	15.80	26.40	58	35.10	57.30	31.50	52.70	58	52.60	85.90	47.20	79.00
59	18.80	30.80	17.00	28.20	59	37.70	61.60	33.90	56.30	59	56.50	92.40	50.70	84.40
60	20.20	33.10	18.30	30.10	60	40.50	66.30	36.40	60.20	60	60.70	99.40	54.50	90.20
61	21.70	35.60	19.60	32.10	61	43.50	71.30	39.10	64.30	61	65.20	106.90	58.60	96.40
62	23.30	38.30	21.00	34.30	62	46.70	76.70	42.00	68.70	62	70.00	115.00	63.00	103.00
63	25.10	41.30	22.70	37.10	63	50.40	82.70	45.30	74.20	63	75.40	124.00	68.00	111.40
64	27.10	44.60	24.50	40.10	64	54.30	89.20	48.90	80.20	64	81.30	133.80	73.30	120.40
65	29.20	48.10	26.40	43.40	65	58.50	96.20	52.70	86.70	65	87.70	144.30	79.10	130.10
66	31.50	51.90	28.50	46.90	66	63.10	103.80	56.80	93.70	66	94.60	155.70	85.30	140.60
67	34.00	56.00	30.70	50.70	67	68.00	112.00	61.30	101.30	67	102.00	168.00	92.00	152.00
68	36.70	60.50	33.20	54.60	68	73.40	120.70	66.10	109.10	68	110.00	181.20	99.40	163.60
69	39.60	65.20	35.80	58.80	69	79.20	130.20	71.40	117.50	69	118.70	195.40	107.30	176.20
70	42.70	70.30	38.60	63.30	70	85.40	140.40	77.10	126.50	70	128.00	210.70	115.80	189.70
71	46.10	75.80	41.70	68.10	71	92.10	151.40	83.30	136.20	71	138.10	227.20	125.00	204.30
72	49.70	81.70	45.00	73.30	72	99.30	163.30	90.00	146.70	72	149.00	245.00	135.00	220.00
73	53.30	87.50	48.20	78.60	73	106.30	174.90	96.40	157.30	73	159.70	262.40	144.60	235.90
74	57.10	93.70	51.60	84.30	74	113.90	187.30	103.20	168.70	74	171.00	281.00	154.80	253.00
75	61.10	100.30	55.20	90.40	75	122.00	200.60	110.50	180.90	75	183.10	300.90	165.70	271.30
76	65.40	107.40	59.10	97.00	76	130.70	214.80	118.30	194.00	76	196.10	322.20	177.40	290.90
77	70.00	115.00	63.30	104.00	77	140.00	230.00	126.70	208.00	77	210.00	345.00	190.00	312.00
78	73.50	120.80	66.30	109.20	78	147.00	241.50	132.80	218.40	78	220.50	362.10	199.00	327.60
79	77.20	126.80	69.50	114.70	79	154.40	253.50	139.10	229.30	79	231.50	380.20	208.50	343.90
80	81.10	133.10	72.80	120.40	80	162.10	266.10	145.70	240.70	80	243.10	399.20	218.50	361.10
81	85.10	139.70	76.30	126.40	81	170.20	279.40	152.70	252.70	81	255.20	419.10	229.00	379.10
82	89.30	146.70	80.00	132.70	82	178.70	293.30	160.00	265.30	82	268.00	440.00	240.00	398.00
83	93.70	154.10	83.90	139.30	83	187.60	307.90	167.60	278.50	83	281.40	461.90	251.50	417.80
84	98.30	161.80	88.00	146.20	84	197.00	323.20	175.60	292.40	84	295.50	484.90	263.60	438.60

**Additional Premium Rate Factors**

Spouse Discount Factor: 0.900  
 Tobacco Rate Up: 1.100

**Modal Factors**

Semi-Annual 0.5150  
 Quarterly 0.2600  
 Monthly (Direct Bill): 0.0900  
 Monthly (Bank Draft): 0.0840

SERFF Tracking Number: GRTT-128519381 State: Arkansas  
 Filing Company: Guarantee Trust Life Insurance Company State Tracking Number:  
 Company Tracking Number: G1181  
 TOI: H131 Individual Health - Short Term Care Sub-TOI: H131.002 Nursing Home  
 Product Name: Recovery Care  
 Project Name/Number: Recovery Care/G1181

## Supporting Document Schedules

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Flesch Certification	Approved-Closed	06/27/2012
<b>Comments:</b>		
<b>Attachment:</b> Readability Certification.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Application	Approved-Closed	06/27/2012
<b>Comments:</b>		
<b>Attachment:</b> Recovery Care Policy App April 30, 2012_VER 14.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Health - Actuarial Justification	Approved-Closed	06/27/2012
<b>Comments:</b>		
<b>Attachment:</b> STC Actuarial Memorandum.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Outline of Coverage	Approved-Closed	06/27/2012
<b>Comments:</b>		
<b>Attachment:</b> OCG1181-Outline of Coverage.pdf		

	<b>Item Status:</b>	<b>Status Date:</b>
<b>Satisfied - Item:</b> Statement of Readability	Approved-Closed	06/27/2012
<b>Comments:</b>		

*SERFF Tracking Number:*      *GRTT-128519381*                      *State:*                      *Arkansas*  
*Filing Company:*              *Guarantee Trust Life Insurance Company*              *State Tracking Number:*  
*Company Tracking Number:*      *G1181*  
*TOI:*                      *H131 Individual Health - Short Term Care*              *Sub-TOI:*                      *H131.002 Nursing Home*  
*Product Name:*              *Recovery Care*  
*Project Name/Number:*              *Recovery Care/G1181*

**Attachment:**

AR Readability Certification.pdf

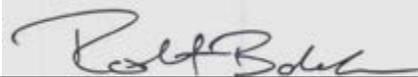
## CERTIFICATE OF READABILITY

Form Number(s): G1181, OCG1181, RG11HHC, RG11IPB, RG11IPG and APPH9-11

Flesch Test Score(s): 50.12; 50.04; 58.23; 57.10, 53.93 and 55.84 respectively

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



\_\_\_\_\_  
General Counsel

Date: June 27, 2012

**Application for Short-Term Nursing Home Care Indemnity Insurance Policy**  
**Guarantee Trust Life Insurance Company**  
1275 Milwaukee Avenue Glenview, IL 60025 (800) 338-7452

**(A) 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: \_\_\_\_\_

**APPLICANT(S) INFORMATION**

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

**Applicant 1**

1. Last Name \_\_\_\_\_ 2. First \_\_\_\_\_ 3. M.I. \_\_\_\_\_  
4. Social Security # \_\_\_\_\_ 5. Age \_\_\_\_\_ 6. Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
7. Height (ft/in) \_\_\_\_\_ 8. Weight \_\_\_\_\_ lbs 9.  Male  Female

**Applicant 2**

10. Last Name \_\_\_\_\_ 11. First \_\_\_\_\_ 12. M.I. \_\_\_\_\_  
13. Social Security # \_\_\_\_\_ 14. Age \_\_\_\_\_ 15. Date of Birth \_\_\_\_/\_\_\_\_/\_\_\_\_  
16. Height (ft/in) \_\_\_\_\_ 17. Weight \_\_\_\_\_ lbs 18.  Male  Female

**Address**

19. Street Address \_\_\_\_\_ 20. City \_\_\_\_\_ 21. State \_\_\_\_ 22. Zip Code \_\_\_\_\_  
23. Applicant 1 E-mail \_\_\_\_\_ 24. Applicant 2 E-mail \_\_\_\_\_  
25. Applicant 1 Phone \_\_\_\_\_ 26. Applicant 2 Phone \_\_\_\_\_

**(B) Plan Applied For Applicant 1**

**Nursing Home/Assisted Living Facility**

**1. Select Daily Benefit Amount:**

\$50 - \$300/day (in \$10 dollar increments): \$ \_\_\_\_\_

**2. Benefit Period:**

30    45    60    90    180    360 Days

**3. Elimination Period:**

0 Days    20 Days

**(B) Plan Applied For Applicant 2**

**Nursing Home/Assisted Living Facility**

**8. Select Daily Benefit Amount:**

\$50 - \$300/day (in \$10 dollar increments): \$ \_\_\_\_\_

**9. Benefit Period:**

30    45    60    90    180    360 Days

**10. Elimination Period:**

0 Days    20 Days

**Inflation Rider**

4.  5% Simple Inflation    5% Compound Inflation

**Inflation Rider**

11.  5% Simple Inflation    5% Compound Inflation

**Home Health Rider:**

**5. Benefit Period:**

90 days    180 days

**6. Benefit Amount Per Visit:**    \$25    \$50    \$75

**7. Elimination Period:**    0 Days    20 Days

**Home Health Rider:**

**12. Benefit Period:**

90 days    180 days

**13. Benefit Amount Per Visit:**    \$25    \$50    \$75

**14. Elimination Period:**    0 Days    20 Days

**Choose Premium Payment Mode:**

Monthly Bank Draft    Annual    Semi-Annual  
 Quarterly

Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Draft Date: (other than the 29th, 30th and 31st) \_\_\_\_\_

**Premiums:**

Premiums include an annual \$25 Policy Fee (per applicant)

Applicant 1 Total Premium: \$ \_\_\_\_\_

Applicant 2 Total Premium: \$ \_\_\_\_\_

<b>(C) Pre-Qualification, Medical Information &amp; Exclusions</b>				<b>Applicant 1</b>	<b>Applicant 2</b>
<b>If any applicant answers "YES" to any questions 1, 2 or 3 A-H below, that applicant does not qualify for this coverage:</b>					
1. Is any applicant currently eligible for Medicaid or on early Medicare due to disability (prior to age 65) or disabled?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
2. In the past 10 years has any applicant been treated or diagnosed by a medical professional as having acquired immune deficiency syndrome (AIDS), AIDS related complex (ARC) or human immunodeficiency virus (HIV) infection?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
3. In the past 24 months, has any applicant:					
A. Required the assistance or supervision of any kind to perform activities of daily living such as bathing, dressing, eating, toileting, getting in or out of bed or chair; have an inability to control bowel or bladder function; or need or use a wheelchair, walker, walking aids, scooter, or multi-pronged cane?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
B. Been confined or advised to enter a rehabilitation facility, nursing facility or assisted living facility; or received home health care services?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
C. Had a stroke, Transient Ischemic Attack (TIA); or congestive heart failure, heart or valve surgery or organ transplant (other than corneal)?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
D. Been diagnosed with, or treated for, insulin dependent diabetes or diabetes with neuropathy or with eye or kidney complications?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
E. Been diagnosed or treated for Alzheimer's disease, dementia, memory loss, Parkinson's disease, psychotic disorders, systemic lupus, Multiple Sclerosis, Muscular Dystrophy, cerebral palsy, ALS (Lou Gehrig's disease), or had an amputation due to a disease?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
F. Been diagnosed or treated for Chronic Obstructive Lung or Pulmonary disease; chronic bronchitis or emphysema; respiratory disease requiring the use of oxygen; kidney failure, renal insufficiency, or kidney dialysis; or chronic liver disease?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
G. Been diagnosed or treated for cancer (other than skin cancer), leukemia, lymphoma or malignant melanoma or cancer that has spread from its original site; or alcohol or drug abuse or crippling or rheumatoid arthritis?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
H. Been advised to have tests or medical treatment or surgery that has not been performed or for which results have not been given?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
4. In the past 12 months has any applicant used any tobacco products?				Yes <input type="checkbox"/> No <input type="checkbox"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
5. <b>Has any applicant taken any prescription medications during the past 6 months?</b>				Yes <input type="checkbox"/> No <input type="checkbox"/>	
<b>If yes, complete medication chart below:</b>					
Name	Medication	Reason Prescribed	Name, Address of Doctor		

<b>(D) Applicant(s) Coverage Information:</b>	
1. Will any existing in force hospital, medical, or major medical insurance be replaced or changed if the proposed coverage is issued? (If "YES," please complete the Replacement Form)	Yes <input type="checkbox"/> No <input type="checkbox"/>
If "Yes," For Which Applicant? _____	
For Which Company? _____	

## 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 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 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 MIB. I (We) authorize the Company, or its reinsurers, to make a brief report of my (our) personal health information to MIB. This Authorization includes all information about drugs, alcoholism, and mental illness. I (We) understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. Although federal regulations require that the Company inform Me (Us) of the potential that information disclosed pursuant to this authorization may be subject to re-disclosure and no longer be protected if such information is disclosed to a person or entity not covered by the federal privacy regulation, all such information received by the Company pursuant to this authorization will be protected by federal and state privacy laws and regulations. I (We) agree that this Authorization will be valid for 24 months from the date signed, and know that I (We) or my (our) authorized representative may have a photocopy of it.

I (We) have received an Outline of Coverage. If this application is completed electronically, I (We) understand the Outline of Coverage will be delivered electronically or with the policy. If the application is completed over the phone the Outline of Coverage will be delivered with the policy. 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 State

\_\_\_\_\_  
Applicant # 1 Signature

\_\_\_\_\_  
Applicant #2 Signature (if applicable)

**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)	E-mail Address	Agent Code
Agent's Signature		Date

APPH9-11

**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
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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 agree that if any such payment is not honored, whether with or without cause and whether intentionally, or inadvertently, you shall be under no liability at all although such action could result in the forfeiture of insurance.

\_\_\_\_\_  
Printed name of insured if different from premium payer

\_\_\_\_\_  
Premium payer's signature, as it appears on bank records

**NOTICE TO APPLICANT – PARTS 1 AND 2**

**Part 1: Fair Credit Reporting Act and Privacy Act Pre-Notification**

The application you completed for insurance with us, in most cases, gives us all the information we need. In certain cases, we may need more information.

If we need more information, we may get it by talking to other persons you know including, but not limited to, your agent or other insurance companies you have applied to. We may ask an independent “consumer reporting agency” to help us verify facts or get additional facts.

We may collect information concerning your health, job and financial situation, as well as your character, general reputation and mode of living. We will not collect information relating to your sexual orientation.

The personal information we obtain about you is treated as confidential and will not be discussed to other persons or organizations without your written authorization except to the extent necessary as permitted by law, for the conduct of our business. But any information collected by a “consumer reporting agency” may be shared by the agency with others who use such information, but only to the extent which the Fair Credit Reporting Act Permits. You have a right of access, and right of correction, concerning recorded personal information obtained in our file. In order to exercise these rights, you must contact us in writing requesting access or correction.

You have no access right to privileged information. If we used a “consumer reporting agency,” you have the right to: (1) ask to talk with them and (2) ask them about their report. You may write us for the name and address of the agency. This paragraph is not intended as a complete description of your right of access and correction. If you would like a more complete description of our Insurance Information and Privacy Protection Practices, please write: Guarantee Trust Life Insurance Company, 1275 Milwaukee Avenue Glenview, IL 60025.

**Part 2: Notification Regarding 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 MIB, Inc., a non-profit membership organization of life insurance companies, which operates an information exchange on behalf of its members. If you apply to another member company for life or health insurance coverage, or a claim for benefits is submitted to such a company, the MIB, Inc., upon request, will supply such company with the information in its file. Upon receipt of a request from you, the MIB, Inc., will arrange disclosure of any information it may have in your file. If you question the accuracy of the information in the MIB, Inc.’s file, you may contact the MIB, Inc., and seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. The address to the MIB information office is 50 Braintree Hill Park, Suite 400, Braintree Massachusetts 02184-8734, telephone number (866) 692-6901, e-mail address infoline@mib.com. Guarantee Trust Life Insurance Company or its reinsurers may also release information in its file to its reinsurer(s) and to other life insurance companies to whom you may also apply for life or health insurance, or to whom a claim for benefits may be submitted.

**RECEIPT**

**DATE** \_\_\_\_\_

Received of \_\_\_\_\_ the sum of \$ \_\_\_\_\_ and application for insurance to Guarantee Trust Life Insurance Company. If for any reason the application is declined this payment will be refunded. No liability is created or assumed by the Company, except for refund of this payment, until the insurance applied for has been issued.

Agent’s Signature: \_\_\_\_\_

If you do not receive your policy/certificate within 60 days from the date of your application, please write to:

Guarantee Trust Life Insurance Company, 1275 Milwaukee Avenue Glenview, IL 60025

**MAKE CHECK PAYABLE TO: GUARANTEE TRUST LIFE INSURANCE COMPANY**

**GUARANTEE TRUST LIFE INSURANCE COMPANY**  
1275 MILWAUKEE AVENUE, GLENVIEW, IL 60025  
(800) 338-7452

**SHORT-TERM NURSING HOME CARE  
INDEMNITY INSURANCE POLICY  
OUTLINE OF COVERAGE**

For Policy Form G1181  
[With Optional Rider Forms RG11HHC, RG11IPB and RG11IPG]

**CAUTION:** The policy was issued based on your answers to the questions on your Application. A copy of your Application will be attached to your policy. If your answers are incorrect or untrue, we may have the right to deny benefits or rescind your policy. The best time to clear up any questions is now, before a claim arises! If, for any reason, any of your answers are incorrect, contact us within 30 days at 1275 Milwaukee, Glenview, Illinois 60025.

If you have any questions concerning this coverage, or if we can be of any assistance, please call us at  
**1-800-338-7452**

**NOTICE TO BUYER**

THE POLICY MAY NOT COVER ALL OF THE COSTS ASSOCIATED WITH SHORT-TERM NURSING HOME CARE INCURRED BY THE BUYER DURING THE PERIOD OF COVERAGE. THIS IS A LIMITED POLICY. THE BUYER IS ADVISED TO REVIEW CAREFULLY ALL POLICY LIMITATIONS AND EXCEPTIONS.

**POLICY DESIGNATION**

The policy is an individual policy of insurance.

**PURPOSE OF OUTLINE OF COVERAGE**

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

**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 premium 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**. We may change your premium by giving you at least thirty-one (31) days prior written notice. We can only do this when we change the premiums for all policies of this class in the state where you live.

**TERMS UNDER WHICH THIS POLICY MAY BE RETURNED AND PREMIUM REFUNDED**

First 30 days: If you return the policy to us or to our agent to be canceled within 30 days of receiving it, we will pay you all premium paid for the policy. After the policy has been returned it will be considered to have never been issued.

After the first 30 days: You may still terminate this coverage if you send written notice. We will end the coverage effective upon receipt or on a later date if specified in the notice. The termination will not affect any claim which was covered prior to the effective date of termination.

In the event of your death, we will refund any premium paid for a period beyond the date of your death.

**THIS IS NOT MEDICARE SUPPLEMENT COVERAGE**

If you are eligible for Medicare, review the *Guide to Health Insurance for People with Medicare* available from us. Neither Guarantee Trust Life Insurance Company nor its agents represent Medicare, the federal government or any state government.

**LIMITED BENEFIT HEALTH INSURANCE COVERAGE**

Policies of this category are designed to provide persons insured with limited or supplemental coverage.

The policy provides coverage on an indemnity basis for covered short-term nursing home and assisted living facility care. All benefits are subject to the limitations and exceptions described in the policy.

**BENEFITS PROVIDED BY THE POLICY**

Elimination Period \_\_\_\_\_ days

Benefit Period \_\_\_\_\_ days

Daily Benefit Amount \$ \_\_\_\_\_

**QUALIFYING FOR BENEFITS AND BENEFIT LIMITATIONS**

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**A. QUALIFYING FOR BENEFITS**

Before benefits will be payable for Covered Care:

1. a Licensed Health Care Practitioner must certify that the services received for Covered Care available under this policy are needed pursuant to a Plan of Care;
2. You have a Functional Disability; and
3. You satisfy the Elimination Period, if any.

We may periodically review the necessity of care and treatment. Our review, for example, may include: (a) diagnosis, symptoms, complaints, and complications of a condition; (b) the reason for the services being rendered; (c) a Licensed Health Care Practitioner’s orders; (d) schedule of treatment; (e) physical limitations and impairments; and (f) the objectives of the Licensed Health Care Practitioner’s Plan of Care.

**B. LIMITATION ON BENEFITS**

Subject to the Qualifying For Benefits and Benefit Limitations provision, we’ll pay the Daily Benefit Amount for all Covered Care available under this policy. We’ll pay for such Covered Care received during Any One Period of Care.

We won’t pay more than the number of Benefit Period days, as shown in the policy schedule, during Any One Period of Care for all benefits available under this policy. Any One Period of Care can only be restored once during the life of the policy. Any days which remain unpaid during Any One Period of Care cannot be carried forward and added to the Benefit Period of the next Any One Period of Care.

We won’t pay benefits for more days than are available under the Maximum Benefit Period during the life of the policy.

Covered Care is incurred on the date the service or treatment is given or the supply is bought. Covered Care must be incurred while this coverage is in force.

**C. COVERED CARE MEANS:**

1. Nursing Home Care:  
The care (including room, board, services and supplies) provided for each day of care during a Nursing Home stay for all levels of care (skilled, intermediate, or custodial).
2. Assisted Living Facility Care  
  
The care (including room, board, services and supplies) provided during a stay in an Assisted Living Facility.

We will only pay one Daily Benefit Amount on any day You incur Nursing Home Care and Assisted Living Facility Care on the same day.

**DEFINITIONS**

**Activities of Daily Living** means the following (6) basic activities of daily living:

1. **Bathing** means washing oneself by sponge bath in either a tub or shower, including the task of getting into or out of the tub or shower.
2. **Continence** means the ability to maintain control of bowel or bladder function; or, when unable to maintain control of bowel or bladder function, the ability to perform associated personal hygiene (including caring for a catheter or colostomy bag).
3. **Dressing** means the ability to put on or take off all items of clothing and any necessary braces, fasteners or artificial limbs.
4. **Eating** means the ability to feed oneself by getting food into the body from a receptacle (e.g., plate, cup, table) or by a feeding tube or intravenously.
5. **Toileting** means the ability to get to and from the toilet, getting on and off the toilet, and performing associated personal hygiene.
6. **Transferring** means the ability to move into or out of a bed, chair or wheelchair without assistance.

**Cognitive Impairment** means a deterioration or loss in intellectual capacity which requires Substantial Supervision to protect oneself from threats to health and safety. Cognitive Impairment is measured by clinical evidence and standardized tests that reliably measure impairment in one's: (1) short or long-term memory; (2) orientation as to people, places, or time; and (3) deductive or abstract reasoning.

Such loss of intellectual capacity can result from the following covered conditions: Alzheimer's Disease, Parkinson's Disease, senile dementia or other nervous or mental disorders of organic origin.

**Functionally Disabled/Functional Disability** means an Insured who is:

1. unable to perform at least 2 Activities of Daily Living without human assistance or supervision; or
2. requires Substantial Supervision to protect such individual from threats to health and safety due to Cognitive Impairment.

## **EXCEPTIONS**

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We won't pay for treatment, care, services or supplies which are:

1. due to war or act of war whether declared or not;
2. due to intentionally self-inflicted Injury while sane or insane;
3. for services or supplies provided by a member of the Immediate Family; an individual who normally resides with you on a regular basis; or in a facility owned or operated by a member of the Immediate Family;
4. for services and supplies not included in your Plan of Care;
5. for which no charge is customarily made in the absence of insurance;
6. for care received outside the United States or its territories; or
7. for alcoholism, drug addiction, or chemical dependency, unless as a result of a medication prescribed by a Doctor.

## **PRE-EXISTING CONDITION LIMITATION**

Coverage under the Policy is subject to a pre-existing conditions limitation. Pre-existing conditions are those medical conditions disclosed or not disclosed on the application for which medical advice or treatment was recommended or received from a Doctor within 6 months prior to the Effective Date of your coverage.

Any loss due to a pre-existing condition isn't covered unless the loss begins more than 6 months after the Effective Date of coverage.

## **THE POLICY MAY NOT COVER ALL OF THE EXPENSES ASSOCIATED WITH YOUR NURSING HOME NEEDS**

### **RELATIONSHIP OF COST OF CARE AND BENEFITS.**

Because the costs of nursing home services will likely increase over time, you should consider whether and how the benefits of this plan may be adjusted. Your benefits will not increase unless you elect one of the optional Inflation Protection Benefit Riders. There is an additional premium for this option.

**DENIAL OF APPLICATION.**

Guarantee Trust Life Insurance will refund any premiums within 30 days of denial of an application.

**[OPTIONAL SHORT-TERM HOME HEALTH CARE INSURANCE RIDER**

Before Home Health Care benefits will be payable for an Insured's Covered Home Care:

1. a Licensed Health Care Practitioner must certify that the Home Health Care services are needed because the Insured has a Functional Disability as defined within this rider; and
2. Home Health Care services are provided pursuant to a Plan of Care; and
3. You satisfy the Elimination Period, if any.

**Functionally Disabled/Functional Disability** means an Insured who:

1. is unable to perform at least 2 Activities of Daily Living without human assistance or supervision; or
2. requires Substantial Supervision to protect such individual from threats to health and safety due to Cognitive Impairment.

**Home Health Care** means medical and non-medical services provided by a Home Health Care Practitioner in your Home.

**Home Health Care Practitioner** means an individual who is qualified to provide Home Health Care. A Home Health Care Practitioner includes the following: a home health aide; a provider of medical or social services; a registered professional nurse (RN); a licensed practical nurse (LPN); a licensed vocational nurse (LVN); a licensed speech therapist or audiologist; a licensed respiratory therapist; a licensed physical therapist; a licensed chemotherapy specialist; or a licensed nutritional therapist. A Home Health Care Practitioner whose specialty is not listed here may be used if approved by us prior to the practitioner providing the service. A Home Health Care Practitioner:

1. must be licensed in the state, or recognized as such by the state in which the care is given;
2. may not be an Insured;
3. may not reside at your address;
4. must present a charge for the care given which you are legally obligated to pay; and
5. must be employed or contracted by a Home Health Care Agency.

**BENEFITS PROVIDED BY THE HOME HEALTH CARE RIDER**

Home Health Care Elimination Period \_\_\_\_\_ days  
 Home Health Care Daily Benefit Amount \_\_\_\_\_ per visit  
 Home Health Care Benefit Maximum \_\_\_\_\_ visits

Adding this benefit to your policy will increase your policy premium by \_\_\_\_\_.]

**[OPTIONAL SIMPLE INCREASING INFLATION PROTECTION BENEFIT RIDER**

We will increase your initial Daily Benefit Amount by 5% on each policy anniversary. The initial Daily Benefit Amount and the Inflation Period are shown on the Policy Schedule. Each 5 percent increase will be added to the Daily Benefit Amount then in effect.

Adding this benefit to your policy will increase your policy premium by \_\_\_\_\_.]

**[OPTIONAL COMPOUND INCREASING INFLATION PROTECTION BENEFIT RIDER**

One year after this rider's Effective Date, provided the policy to which it is attached is in force, we will increase your initial Daily Benefit Amount for Any One Period of Care by 5%. (The Daily Benefit Amount for Any One Period of Care is shown on the Policy Schedule.) On each subsequent policy anniversary, we will continue to increase your current Daily Benefit Amount for Any One Period of Care (which includes prior year(s) increases) by 5%. These increases will continue to take place on each policy anniversary for the Inflation Period specified on the Policy Schedule. The increases occur whether or not you are receiving benefits under the policy.

Adding this benefit to your policy will increase your policy premium by \_\_\_\_\_.]

**THIS SHORT-TERM NURSING HOME CARE INDEMNITY INSURANCE POLICY DOES NOT QUALIFY THE INSURED FOR THE FAVORABLE TAX TREATMENT PROVIDED FOR IN THE INTERNAL REVENUE CODE OF 1986, SECTION 7702(B) AS ENACTED BY “THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT” OF 1996.**

**GUARANTEED RENEWABLE FOR LIFE** You may keep this Policy, and Riders if attached, in force during Your entire lifetime, unless otherwise stated in the Rider, by paying the renewal premium at the intervals available to You at time of renewal. You must pay the renewal premium by its due date or during the 31 days that follow. We cannot cancel or refuse to renew this Policy or place any restrictions on it if You pay Your premiums on time.

**PREMIUMS SUBJECT TO CHANGE** We may change the premium rates for this Policy/Riders by giving You at least 31 days prior written notice of any change in the renewal premium. We can only change the premium if We change it for all Policies/Riders like Yours in Your state on a class basis.

**PREMIUM.**

Total annual policy premium for coverage that You applied for is:

**COVERAGE**

Policy	\$_____
[Optional Home Health Care Rider	\$_____]
[Optional Inflation Protection Benefit Rider	\$_____]
TOTAL \$_____	

*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.*

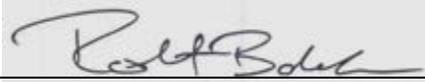
## CERTIFICATE OF READABILITY

Form Number(s): G1181-AR, OCG1181, RG11HHC, RG11IPB, RG11IPG and APPH9-11

Flesch Test Score(s): 50.12; 50.04; 58.23; 57.10, 53.93 and 55.84 respectively

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



General Counsel

Date: June 27, 2012