

State: Arkansas **Filing Company:** Guarantee Trust Life Insurance Company
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
Product Name: Amendment Rider
Project Name/Number: /RA12-8

Filing at a Glance

Company: Guarantee Trust Life Insurance Company
Product Name: Amendment Rider
State: Arkansas
TOI: H071 Individual Health - Specified Disease - Limited Benefit
Sub-TOI: H071.001 Critical Illness
Filing Type: Form/Rate
Date Submitted: 12/21/2012
SERFF Tr Num: GRTT-128816035
SERFF Status: Closed-Approved-Closed
State Tr Num:
State Status: Approved-Closed
Co Tr Num: RA12-8

Implementation: On Approval
Date Requested:
Author(s): Joan Jannotta, Ann Ryan, Frances Markiewicz
Reviewer(s): Rosalind Minor (primary)
Disposition Date: 01/03/2013
Disposition Status: Approved-Closed
Implementation Date:

State Filing Description:

State: Arkansas **Filing Company:** Guarantee Trust Life Insurance Company
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
Product Name: Amendment Rider
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General Information

Project Name: Status of Filing in Domicile: Pending
Project Number: RA12-8 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: 01/03/2013
State Status Changed: 01/03/2013
Deemer Date: Created By: Frances Markiewicz
Submitted By: Joan Jannotta Corresponding Filing Tracking Number:

Filing Description:

Amendment Rider RA12-8
Amendment Rider RA12-9
Outline of Coverage OCG1130A
Outline of Coverage OCG1131A
Application APPH3-12
Application APPH3-12-N/S
Actuarial Memorandum and Rates

We are submitting the above referenced forms, actuarial memorandum and rates for the Department's review and approval.

The riders new and not intended to replace any forms currently on file at the Department. The forms will be marketed to individuals by contracted agents and brokers.

The riders will be added to new issues of Lump Sum Cancer policy form G1130-AR and Lump Sum Heart Attack or Stroke Policy form G1131-AR, respectively. The rider adds a 30 day waiting period. The rider will only be added to new issues. It will not be added to inforce coverage. Policy forms G1130-AR and G1131-AR were approved by your Department on October 28, 2011 under serff filing number GRTT-127701250.

In the solicitation of these products we will use application APPH3-12 and APPH3-12-N/S. The "-N/S" version does not include the smoking question. We have included them in this filing for approval. We would appreciate general approval of these applications so that they may be used with similar products approved by your state. Any bracketed information in the application is variable. It is not our intention to make any changes that would cause this application to be out of compliance with any statutory requirements.

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

We are also submitting a new memorandum and factors to be used with the application with the smokers question. The factors will be applied to the rates which have already been approved for use with this product.

Thank you for your time and attention to this filing. If you have any questions, please contact me toll free at 800-338-7452, ext. 5730 or e-mail me at jjannotta@gtlic.com.

State: Arkansas **Filing Company:** Guarantee Trust Life Insurance Company
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
Product Name: Amendment Rider
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Company and Contact

Filing Contact Information

Joan Jannotta, jjannotta@gtlic.com
 1275 Milwaukee Ave. 847-904-5730 [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]		

Filing Fees

Fee Required? Yes
Fee Amount: \$250.00
Retaliatory? No
Fee Explanation: 4 forms at \$50.00 each, plus \$50 for rates, equals \$250.00.
Per Company: No

Company	Amount	Date Processed	Transaction #
Guarantee Trust Life Insurance Company	\$250.00	12/21/2012	65975007

SERFF Tracking #:

GRTT-128816035

State Tracking #:

Company Tracking #:

RA12-8

State:

Arkansas

Filing Company:

Guarantee Trust Life Insurance Company

TOI/Sub-TOI:

H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name:

Amendment Rider

Project Name/Number:

/RA12-8

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved-Closed	Rosalind Minor	01/03/2013	01/03/2013

Objection Letters and Response Letters

Objection Letters

Status	Created By	Created On	Date Submitted
Pending Industry Response	Rosalind Minor	01/02/2013	01/02/2013

Response Letters

Responded By	Created On	Date Submitted
Joan Jannotta	01/03/2013	01/03/2013

State: Arkansas **Filing Company:** Guarantee Trust Life Insurance Company
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
Product Name: Amendment Rider
Project Name/Number: /RA12-8

Disposition

Disposition Date: 01/03/2013

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 req'd):	Minimum % Change (where req'd):
Guarantee Trust Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

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 Variability	Approved-Closed	Yes
Form	Lump Sum Cancer Amendment Rider	Approved-Closed	Yes
Form	Heart Attack or Stroke Amendment Rider	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Form	Application	Approved-Closed	Yes
Rate	Tobacco Rate Factors	Approved-Closed	Yes

State: Arkansas **Filing Company:** Guarantee Trust Life Insurance Company
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
Product Name: Amendment Rider
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Objection Letter

Objection Letter Status	Pending Industry Response
Objection Letter Date	01/02/2013
Submitted Date	01/02/2013
Respond By Date	

Dear Joan Jannotta,

Introduction:

This will acknowledge receipt of the captioned filing.

Objection 1

- Lump Sum Cancer Amendment Rider , RA12-8 (Form)
- Heart Attack or Stroke Amendment Rider, RA12-9 (Form)

Comments: Please confirm if the waiting period is not greater than 30 days as outlined under Rule and Regulation 18, APPENDIX 1 A(5).

Conclusion:

A.C.A. 23-79-109(1)-(5) sets forth the procedure by which filings may be deemed approved upon the expiration of certain time periods with no affirmative action by the commissioner. If the commissioner determines that additional information is needed to make a decision regarding approval, such request for information will be made to the company. The filing will not be considered complete until said additional information is received. The time periods set forth in this statute will not begin to run until the filing is complete.

Please feel free to contact me if you have questions.

Sincerely,

Rosalind Minor

State: Arkansas **Filing Company:** Guarantee Trust Life Insurance Company
TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness
Product Name: Amendment Rider
Project Name/Number: /RA12-8

Response Letter

Response Letter Status Submitted to State
Response Letter Date 01/03/2013
Submitted Date 01/03/2013

Dear Rosalind Minor,

Introduction:

Thank you for your review.

Response 1

Comments:

The waiting period will be 30 days.

Related Objection 1

Applies To:

- Lump Sum Cancer Amendment Rider , RA12-8 (Form)
- Heart Attack or Stroke Amendment Rider, RA12-9 (Form)

Comments: Please confirm if the waiting period is not greater than 30 days as outlined under Rule and Regulation 18, APPENDIX 1 A(5).

Changed Items:

No Supporting Documents changed.

No Form Schedule items changed.

No Rate/Rule Schedule items changed.

Conclusion:

Your further consideration and approval would be appreciated.

Sincerely,

Joan Jannotta

State: Arkansas

Filing Company:

Guarantee Trust Life Insurance Company

TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name: Amendment Rider

Project Name/Number: /RA12-8

Form Schedule

Lead Form Number: RA12-8

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data	Readability Score	Attachments
1	Approved-Closed 01/03/2013	Lump Sum Cancer Amendment Rider	RA12-8	POLA	Initial		52.000	RA12-8.pdf
2	Approved-Closed 01/03/2013	Heart Attack or Stroke Amendment Rider	RA12-9	POLA	Initial		52.000	RA12-9.pdf
3	Approved-Closed 01/03/2013	Application	APPH3A-12	AEF	Initial		45.000	APPH3-12 For Filing.pdf
4	Approved-Closed 01/03/2013	Application	APPH3A- 12-N/S	AEF	Initial		45.000	APPH3-12-NS For Filing.pdf

Form Type Legend:

ADV	Advertising	AEF	Application/Enrollment Form
CER	Certificate	CERA	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	FND	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	NOC	Notice of Coverage
OTH	Other	OUT	Outline of Coverage
PJK	Policy Jacket	POL	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	SCH	Schedule Pages

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

AMENDMENT RIDER

EFFECTIVE DATE: _____

This Amendment 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, it begins on the Effective Date of the Policy.

The following benefit limitation is hereby added to this Policy.

WAITING PERIOD: This Policy includes a Waiting Period, as shown on the Policy Schedule. All benefits payable are subject to the Waiting Period.

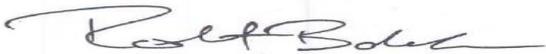
“Waiting Period” means the number of days after the Covered Person’s Effective Date, before We will pay benefits for loss due to Cancer.

Cancer will not be a covered condition when advice or treatment is received during the Waiting Period or prior to the Effective Date, and such advice or treatment results in the First Diagnosis of Cancer. If tissue is extracted during the Waiting Period or prior to the Effective Date, and results in a First Diagnosis of Cancer, this will not be a covered condition. The date of diagnosis is the earlier of the date of clinical diagnosis or the date the specimen used to diagnose Cancer is taken. If Cancer is diagnosed and / or treated within the Waiting Period, OR if medical advice is given within the Waiting Period which leads to the subsequent First Diagnosis of Cancer after the Waiting Period, the Insured has the option to cancel the Policy and receive a refund of all premiums paid on this policy and attached riders. The date of diagnosis is the earlier of the date of clinical diagnosis or the date the specimen used to diagnose Cancer is taken.

If a Covered Person should exercise the Conversion Privilege under the Policy, another Waiting Period in the Conversion policy will not apply.

Conditions

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



Secretary



President

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

AMENDMENT RIDER

EFFECTIVE DATE: _____

This Amendment 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, it begins on the Effective Date of the Policy.

THE FOLLOWING APPLY TO THE HEART ATTACK OR STROKE LUMP SUM BENEFITS

The following benefit limitation is hereby added to this Policy.

WAITING PERIOD: This Policy includes a Waiting Period, as shown on the Policy Schedule. All benefits payable are subject to the Waiting Period.

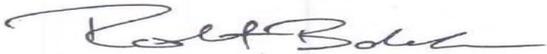
“Waiting Period” means the number of days after the Covered Person’s Effective Date, before We will pay benefits for loss due to a Heart Attack or Stroke.

A Heart Attack or Stroke will not be covered conditions when any advice or treatment is received by the Covered Person prior to the Effective Date or during the Waiting Period. If a Heart Attack or Stroke is diagnosed and / or treated within the Waiting Period, OR if medical advice is given within the Waiting Period which leads to the subsequent First Diagnosis of Heart Attack or Stroke after the Waiting Period, the Insured has the option to cancel the Policy and receive a refund of all premiums paid on this policy and attached riders.

If a Covered Person should exercise the Conversion Privilege under the Policy, another Waiting Period in the Conversion policy will not apply.

Conditions

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



Secretary



President

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

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

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

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

A. APPLICANT(S) INFORMATION

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

APPLICANT:

1. Last Name _____ 2. First _____ 3. M.I. _____
4. Social Security # _____ 5. Male Female 6. Age _____ 7. Date of Birth _____

SPOUSE:

8. Last Name _____ 9. First _____ 10. M.I. _____
11. Social Security # _____ 12. Male Female 13. Age _____ 14. Date of Birth _____

DEPENDENTS:

D1. Last Name _____ First _____ M.I. _____
Social Security # _____ Male Female Age _____ Date of Birth _____
D2. Last Name _____ First _____ M.I. _____
Social Security # _____ Male Female Age _____ Date of Birth _____
D3. Last Name _____ First _____ M.I. _____
Social Security # _____ Male Female Age _____ Date of Birth _____

CONTACT:

15. Street Address _____
16. City _____ 17. State _____ 18. Zip Code _____ 19. County _____
20. Telephone _____ 21. Email Address _____

BENEFICIARY:

Primary Beneficiary _____ Relationship _____
Contingent Beneficiary _____ Relationship _____

B. COVERAGE SELECTION & PREMIUMS

1. Plan Type:

Individual Single Parent Couple Family

2. Stand Alone Cancer Policy:

*Lump Sum Benefit Selected: _____
*Min: \$5,000 (In Increments of \$5,000) Maximum not to exceed \$75,000.

3. Cancer Policy With Heart Attack and Stroke Rider:

*Lump Sum Benefit Selected: _____
*Min: \$5,000 (In Increments of \$5,000) Maximum not to exceed \$75,000.

4. Stand Alone Heart Attack and Stroke Policy:

*Lump Sum Benefit Selected: _____
*Min: \$5,000 (In Increments of \$5,000) Maximum not to exceed \$75,000.

5. Therapy and Wellness Rider:

6. Intensive Care Rider: (Pays \$150 Per Unit Per Day)
 1 Unit 2 Units 3 Units 4 Units

7. Return of Premium Rider (upon death):

8. Premium Payment Mode:

Effective Date: _____ Draft Date: _____
 Monthly Bank Draft Credit Card
 Annual Semi-Annual Quarterly

9. Premium:

(Premium calculated includes a \$20 annual policy fee)
TOTAL: \$ _____

C. PRE QUALIFICATION, MEDICAL INFORMATION & EXCLUSIONS

1. In the past 12 months, has any person to be insured used tobacco products or products containing nicotine of any type?
2. In the past 5 years has any person to be insured, had, been diagnosed as having, received medication for or been treated by a medical professional for:
 - a. Human Immunodeficiency virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions (ARC)?
 - b. Chronic Obstructive Pulmonary Disease (COPD) requiring the use of two or more medications?
 - c. Leukemia, Hodgkin's Disease, lymphoma, malignant melanoma, sarcoma, or any internal cancer, or had radiation or chemotherapy for any of these conditions or a pre-leukemic condition, a pre-malignant condition or a condition with malignant potential?
 - d. Heart attack, heart bypass, angioplasty, angina, congestive heart failure, coronary artery disease, atrial fibrillation, chronic kidney disease, diabetes requiring insulin use, stroke, or Transient Ischemic Attack (TIA)?
3. For any of the conditions which benefits are being applied for, within the past 24 months, has any person to be insured had any abnormal diagnostic test results, awaiting test results, or been advised to have any diagnostic test, or had a medical condition, symptom or abnormality that would have caused a person to seek medical treatment or advice for but not have done so?

Applicant's Answers

Question	YES	NO	Action
1.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," tobacco rates will apply.
2.a.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," do not submit the application.
2.b.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," do not submit the application.
2.c.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Applicant does not qualify for Cancer Plan benefits. Apply for the Heart Attack/Stroke Plan.
2.d.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Applicant does not qualify for Heart Attack/Stroke Plan or benefits.
3.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," do not submit the application.

Spouse's Answer

Question	YES	NO	Action
1.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," tobacco rates will apply.
2.a.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Spouse does not qualify for the Plan.
2.b.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Spouse does not qualify for the Plan.
2.c.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Spouse does not qualify for the Cancer benefits.
2.d.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Spouse does not qualify for Heart Attack/Stroke Plan or benefits.
3.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Spouse does not qualify for the Plan.

Dependent's Answer

Question	YES	NO	Action
1.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," tobacco rates will apply.
2.a.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," dependent(s) _____ does (do) not qualify for the Plan.
2.b.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," dependent(s) _____ does (do) not qualify for the Plan.
2.c.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," dependent(s) _____ does (do) not qualify for Cancer benefits.
2.d.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," dependent(s) _____ does (do) not qualify for Heart Attack/Stroke Plan or benefits.
3.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," dependent(s) _____ does (do) not qualify for the Plan.

D. COVERAGE INFORMATION

APPLICANT:

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

AGENT'S STATEMENT

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

Agent's Name (Printed)

Email Address

Agent Code

Agent's Signature

Date

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

I (We) understand that any changes in my (our) health conditions or that of my (our) dependents (if applying for dependent coverage), 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.

AUTHORIZATION: I (We) authorize Guarantee Trust Life Insurance Company (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company, pharmacy benefit managers, pharmacies, pharmacy-related facilities or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from the Medical Information Bureau. I (We) authorize the Company, or its reinsurers, to make a brief report of my personal health information to the 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) 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.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signed at Date: _____ City and State: _____

Applicant Signature: _____ Spouse Signature (if applicable): _____

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

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

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

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

A. APPLICANT(S) INFORMATION

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

APPLICANT:

1. Last Name _____ 2. First _____ 3. M.I. _____
4. Social Security # _____ 5. Male Female 6. Age _____ 7. Date of Birth _____

SPOUSE:

8. Last Name _____ 9. First _____ 10. M.I. _____
11. Social Security # _____ 12. Male Female 13. Age _____ 14. Date of Birth _____

DEPENDENTS:

D1. Last Name _____ First _____ M.I. _____
Social Security # _____ Male Female Age _____ Date of Birth _____
D2. Last Name _____ First _____ M.I. _____
Social Security # _____ Male Female Age _____ Date of Birth _____
D3. Last Name _____ First _____ M.I. _____
Social Security # _____ Male Female Age _____ Date of Birth _____

CONTACT:

15. Street Address _____
16. City _____ 17. State _____ 18. Zip Code _____ 19. County _____
20. Telephone _____ 21. Email Address _____

BENEFICIARY:

Primary Beneficiary _____ Relationship _____
Contingent Beneficiary _____ Relationship _____

B. COVERAGE SELECTION & PREMIUMS

1. Plan Type:

Individual Single Parent Couple Family

2. Stand Alone Cancer Policy:

*Lump Sum Benefit Selected: _____
*Min: \$5,000 (In Increments of \$5,000) Maximum not to exceed \$75,000.

3. Cancer Policy With Heart Attack and Stroke Rider:

*Lump Sum Benefit Selected: _____
*Min: \$5,000 (In Increments of \$5,000) Maximum not to exceed \$75,000.

4. Stand Alone Heart Attack and Stroke Policy:

*Lump Sum Benefit Selected: _____
*Min: \$5,000 (In Increments of \$5,000) Maximum not to exceed \$75,000.

5. Therapy and Wellness Rider:

6. Intensive Care Rider: (Pays \$150 Per Unit Per Day)
 1 Unit 2 Units 3 Units 4 Units

7. Return of Premium Rider (upon death):

8. Premium Payment Mode:

Effective Date: _____ Draft Date: _____
 Monthly Bank Draft Credit Card
 Annual Semi-Annual Quarterly

9. Premium:

(Premium calculated includes a \$20 annual policy fee)

TOTAL: \$ _____

C. PRE QUALIFICATION, MEDICAL INFORMATION & EXCLUSIONS

1. In the past 5 years has any person to be insured, had, been diagnosed as having, received medication for or been treated by a medical professional for:
 - a. Human Immunodeficiency virus (HIV), Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions (ARC)?
 - b. Chronic Obstructive Pulmonary Disease (COPD) requiring the use of two or more medications?
 - c. Leukemia, Hodgkin's Disease, lymphoma, malignant melanoma, sarcoma, or any internal cancer, or had radiation or chemotherapy for any of these conditions or a pre-leukemic condition, a pre-malignant condition or a condition with malignant potential?
 - d. Heart attack, heart bypass, angioplasty, angina, congestive heart failure, coronary artery disease, atrial fibrillation, chronic kidney disease, diabetes requiring insulin use, stroke, or Transient Ischemic Attack (TIA)?
2. For any of the conditions which benefits are being applied for, within the past 24 months, has any person to be insured had any abnormal diagnostic test results, awaiting test results, or been advised to have any diagnostic test, or had a medical condition, symptom or abnormality that would have caused a person to seek medical treatment or advice for but not have done so?

Applicant's Answers

Question	YES	NO	Action
1.a.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," do not submit the application.
1.b.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," do not submit the application.
1.c.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Applicant does not qualify for Cancer Plan benefits. Apply for the Heart Attack/Stroke Plan.
1.d.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Applicant does not qualify for Heart Attack/Stroke Plan or benefits.
2.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," do not submit the application.

Spouse's Answer

Question	YES	NO	Action
1.a.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Spouse does not qualify for the Plan.
1.b.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Spouse does not qualify for the Plan.
1.c.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Spouse does not qualify for the Cancer benefits.
1.d.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Spouse does not qualify for Heart Attack/Stroke Plan or benefits.
2.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," the Spouse does not qualify for the Plan.

Dependent's Answer

Question	YES	NO	Action
1.a.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," dependent(s) _____ does (do) not qualify for the Plan.
1.b.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," dependent(s) _____ does (do) not qualify for the Plan.
1.c.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," dependent(s) _____ does (do) not qualify for Cancer benefits.
1.d.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," dependent(s) _____ does (do) not qualify for Heart Attack/Stroke Plan or benefits.
2.	<input type="checkbox"/>	<input type="checkbox"/>	If "YES," dependent(s) _____ does (do) not qualify for the Plan.

D. COVERAGE INFORMATION

APPLICANT:

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

AGENT'S STATEMENT

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

Agent's Name (Printed) _____

Email Address _____

Agent Code _____

Agent's Signature _____

Date _____

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

I (We) understand that any changes in my (our) health conditions or that of my (our) dependents (if applying for dependent coverage), 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.

AUTHORIZATION: I (We) authorize Guarantee Trust Life Insurance Company (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company, pharmacy benefit managers, pharmacies, pharmacy-related facilities or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from the Medical Information Bureau. I (We) authorize the Company, or its reinsurers, to make a brief report of my personal health information to the 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) 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.

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

Signed at Date: _____ City and State: _____

Applicant Signature: _____ Spouse Signature (if applicable): _____

SERFF Tracking #:

GRTT-128816035

State Tracking #:

Company Tracking #:

RA12-8

State: Arkansas

Filing Company:

Guarantee Trust Life Insurance Company

TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name: Amendment Rider

Project Name/Number: /RA12-8

Rate Information

Rate data applies to filing.

Filing Method: serff

Rate Change Type: Neutral

Overall Percentage of Last Rate Revision: 0.000%

Effective Date of Last Rate Revision: 12/06/2012

Filing Method of Last Filing: 0

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 req'd):	Minimum % Change (where req'd):
Guarantee Trust Life Insurance Company	0.000%	0.000%	\$0	0	\$0	0.000%	0.000%

SERFF Tracking #:

GRTT-128816035

State Tracking #:**Company Tracking #:**

RA12-8

State:

Arkansas

Filing Company:

Guarantee Trust Life Insurance Company

TOI/Sub-TOI:

H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name:

Amendment Rider

Project Name/Number:

/RA12-8

Rate/Rule Schedule

Item No.	Schedule Item Status	Document Name	Affected Form Numbers (Separated with commas)	Rate Action	Rate Action Information	Attachments
1	Approved-Closed 01/03/2013	Tobacco Rate Factors	G1130-AR, G1131-AR, RG11LSHAS, RG10CTW, RG10IC	New		Lump Sum CHS Tobacco Factors.pdf

Guarantee Trust Life Insurance Company
Limited Benefit Policy Forms G1130 & G1131 and Associated Riders
Tobacco Rating Factors

Tobacco rating factors are applied to non-tobacco-distinct rate tables for:

- > Base Lump Sum Cancer Policy G1130
- > Base Lump Sum Heart Attack & Stroke Policy G1131
- > Lump Sum Heart Attack & Stroke Rider RG11LSHAS
- > Therapy and Wellness Rider RG10TCW
- > Intensive Care Rider RG10IC

Tobacco Factor:	1.176
Non-Tobacco Factor:	0.980

SERFF Tracking #:

GRTT-128816035

State Tracking #:

Company Tracking #:

RA12-8

State: Arkansas

Filing Company:

Guarantee Trust Life Insurance Company

TOI/Sub-TOI: H071 Individual Health - Specified Disease - Limited Benefit/H071.001 Critical Illness

Product Name: Amendment Rider

Project Name/Number: /RA12-8

Supporting Document Schedules

		Item Status:	Status Date:
Satisfied - Item:	Flesch Certification	Approved-Closed	01/03/2013
Comments:	Readability Certification attached.		
Attachment(s):	Readability Certification.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Application	Approved-Closed	01/03/2013
Comments:	Please see forms tab		

		Item Status:	Status Date:
Satisfied - Item:	Outline of Coverage	Approved-Closed	01/03/2013
Comments:	Outlines of Coverage attached.		
Attachment(s):	OCG1130A.pdf OCG1131A.pdf		

		Item Status:	Status Date:
Satisfied - Item:	Statement of Variability	Approved-Closed	01/03/2013
Comments:			
Attachment(s):	Statement of Variability.pdf		

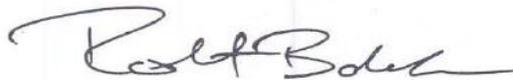
CERTIFICATE OF READABILITY

Form Number(s): RA12-8, RA12-9, APPH3-12, APPH3-12-NS, OCG1030A, OCG1031A

Flesch Test Score(s): 52, 52, 45., 44, 45, 45 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



Robert Baluk, General Counsel

Date: December 17, 2012

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

SPECIFIED DISEASE POLICY
First Diagnosis and Reoccurrence Benefits

OUTLINE OF COVERAGE
FOR POLICY FORM G1130

KEEP THIS OUTLINE FOR YOUR RECORDS

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

THIS IS A LIMITED BENEFIT POLICY – PLEASE READ YOUR POLICY CAREFULLY - This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. Your policy sets forth in details the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

SPECIFIED DISEASE COVERAGE – Policies of this category are designed to provide persons insured, restricted coverage paying benefits **ONLY** when certain losses occur as a result of specified disease. Coverage is not provided for basic hospital, basic medical-surgical, or major medical or comprehensive expenses.

CANCER LUMP SUM BENEFIT

We will pay a lump sum benefit, as shown below, if a covered person is diagnosed with cancer after the Effective Date of coverage, subject to any Waiting Period, and while the policy is in force.

FIRST DIAGNOSIS BENEFIT: The First Diagnosis Cancer Lump Sum benefit is limited to one Lump Sum benefit amount during each covered person's lifetime under the Policy.

REOCCURRENCE BENEFIT: We will pay a Reoccurrence Benefit for a previously diagnosed or newly diagnosed Cancer. Benefit payment is subject to a covered person having been in a period of remission for at least one full year from a previously diagnosed Cancer for which we have previously paid benefits under this policy. For benefit eligibility, reoccurrence must be separated by at least one full year from the date we paid benefits for a first diagnosis of Cancer, or the year in which a new cancer is diagnosed.

The Reoccurrence Benefit is a percentage (10% to 100%, depending upon the number of years elapsed) of the First Diagnosis Lump Sum Benefit amount. The Reoccurrence Benefit is not subject to a lifetime maximum.

Benefits for the reoccurrence of a previously diagnosed Cancer are subject to documented medical evidence that supports a Cancer's period of remission.

This policy is subject to a pre-existing condition limitation. A pre-existing condition is a condition for which: (a) medical advice or treatment was recommended by, or received from, a doctor within the 24-month period before the effective date of the covered person's coverage; or (b) symptoms existed which would have caused an ordinarily prudent person to seek diagnosis, care or treatment within the 24-month period before the effective date of the covered person's coverage.

[OPTIONAL BENEFIT RIDERS]

[HEART ATTACK OR STROKE LUMP SUM BENEFIT RIDER: We will pay a lump sum benefit, as shown below, if a covered person is diagnosed with a Heart Attack or Stroke after the Effective Date of coverage and while the policy is in force with this rider. **This rider is subject to a pre-existing condition limitation.** (Please refer to the description of a pre-existing condition limitation shown on page 1.)

FIRST DIAGNOSIS BENEFIT: The First Diagnosis Lump Sum benefit is limited to one Lump Sum benefit amount during each covered person's lifetime under the Policy.

REOCCURRENCE BENEFIT: We will pay a Reoccurrence Benefit when a covered person experiences a Heart Attack or Stroke at least one full year after payment of the First Diagnosis Lump Sum Benefit under this rider.

The Reoccurrence Benefit is a percentage of the First Diagnosis Lump Sum benefit amount (10% to 100%) and is based upon the number of years between the prior Heart Attack or Stroke event and the year the subsequent Heart Attack or Stroke event occurs / reoccurs. Benefits payable under this provision are subject to the Covered Person being free of treatment (except for maintenance medication(s) and follow-up examinations) for at least one full year prior to the reoccurrence.

CORONARY ANGIOPLASTY OR CORONARY ARTERY BYPASS SURGERY BENEFIT: This benefit is payable when a covered person undergoes a Coronary Angioplasty or Coronary Artery Bypass Surgery. To be eligible for this benefit:

- a. Medical advice to undergo Coronary Angioplasty or Coronary Artery Bypass Surgery must be received after the rider's effective date;
- b. Coronary Angioplasty or Coronary Artery Bypass Surgery must be performed while insured under this rider; and
- c. Coronary Angioplasty or Coronary Artery Bypass Surgery must not be performed as a direct result of a Heart Attack which immediately preceded the procedure or surgery.]

[THERAPY AND WELLNESS BENEFIT RIDER: This rider pays an indemnity benefit for specified health and wellness screenings. The benefit is limited to one payment per calendar year per covered person. The rider also provides benefits for therapy (physical, speech, hearing and occupational), educational services, mental health, healthy lifestyle programs and alternative care.]

[INTENSIVE CARE BENEFIT RIDER: This rider pays an indemnity benefit for confinement in an intensive care unit due to injury or sickness. A benefit of 50% for a step down unit is available. The benefit is doubled if confinement is due to and within 48 hours of an accident. **This rider is subject to a 30-day waiting period limitation.** This means rider benefits are payable when an intensive care confinement begins at least 30 days after a covered person's effective date of coverage.]

[RETURN OF PREMIUM BENEFIT RIDER (Payable Upon Completion of Specified Return of Premium Period): This rider may provide a return of premium benefit in the event your policy remains in force for [15] [20] [25] full years. The actual amount of premium that will be returned, if any, will be equal to 100% of all premiums you paid for the policy and any other benefit riders attached to the policy (unless expressly excluded), while this rider was in force (except for any application or annual policy fee) MINUS all benefits paid or then payable under the policy for you or any dependent(s). NOTE: The sum of all premiums is without interest accumulation.

At the end of the Return of Premium Period, you will have the option of renewing this rider. Renewal is conditioned upon the new Return of Premium Period beginning before your attained age 80.]

[RETURN OF PREMIUM UPON DEATH BENEFIT RIDER: The rider provides for a return of premium in the event of your death within 10 years of this rider's effective date, or death occurring prior to your age 85, whichever is later. The actual amount of premium that will be returned, if any, will be equal to 100% of all premiums you paid for the policy and any other benefit riders attached to the policy (unless expressly excluded), while this rider was in force (except for any application or annual policy fee) MINUS all benefits paid or then payable under the policy for you or any dependent(s). NOTE: The sum of all premiums is without interest accumulation.]

POLICY EXCLUSIONS

We will not pay a benefit for:

1. Any Cancer diagnosed before the effective date of the covered person’s coverage under the policy; or
2. Any loss due to injury, disease, or incapacity, unless related to or attributable to cancer, as defined.

[The following are exclusions that apply to the optional benefit riders.]

[Heart Attack or Stroke Lump Sum Benefit Rider

We will not pay a benefit for:

1. Heart Attack or Stroke if first diagnosed before the effective date of the covered person’s coverage under the rider;
2. Coronary Angioplasty or Coronary Artery Bypass Surgery where medical advice to undergo such procedure or surgery was received before the rider’s effective date; or
3. Any loss due to injury, disease or incapacity, unless related to or attributable to Heart Attack or Stroke.]

[Therapy and Wellness AND] [Intensive Care Benefit Riders]

1. [Intentionally self-inflicted injury, violating or attempting to violate any duly enacted law.
2. Injury by acts of war, whether declared or not.
3. Attempted suicide while sane or insane.
4. Injury sustained while committing or attempting to commit a felony.
5. Injury sustained while voluntarily participating in a riot, or civil commotion or disturbance of any kind.
6. Loss of resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the injury occurs.
7. Loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a doctor.]

WAITING PERIOD - There is a 30 day waiting period before we will pay benefits for a loss covered by the policy and attached riders. We will not pay benefits for covered conditions diagnosed or procedures performed during the waiting period.

RENEWABILITY - You may keep the policy and riders, if attached, in force during your entire lifetime by paying premiums when due or within the grace period. We cannot cancel or refuse to renew the policy or place any restrictions on it if you pay your premiums on time.

PREMIUMS ARE SUBJECT TO CHANGE - We may change your premium rates by giving you at least 31 days prior written notice. We can change the premium this way only if we change it on a class basis for all policies and riders of this class in your state.

INITIAL PREMIUM

COVERAGE DESCRIPTION	BENEFIT (AMOUNT/UNITS/TERM)	PREMIUM
Cancer Lump Sum Policy	Amount: \$ _____	\$ _____
[Heart Attack or Stroke Lump Sum Benefit Rider	Amount: \$ _____	\$ _____]
[Return of Premium Benefit Rider	<input type="checkbox"/> [15] [20] [25] Years <input type="checkbox"/> [Upon Death]	\$ _____]
[Intensive Care Benefit Rider	Units: _____	\$ _____]
[Therapy & Wellness Benefit Rider	Units: _____	\$ _____]
Annual Policy Fee:		\$ 20.00
TOTAL ANNUAL PREMIUM: \$ _____		

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 and therefore, removing them from this outline of coverage.

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

SPECIFIED DISEASE POLICY
First Diagnosis and Reoccurrence Benefits

OUTLINE OF COVERAGE
FOR POLICY FORM G1131

KEEP THIS OUTLINE FOR YOUR RECORDS

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

THIS IS A LIMITED BENEFIT POLICY – PLEASE READ YOUR POLICY CAREFULLY - This Outline of Coverage provides a very brief description of the important features of your policy. This is not the insurance contract and only the actual policy provisions will control. Your policy sets forth in details the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR POLICY CAREFULLY!**

SPECIFIED DISEASE COVERAGE – Policies of this category are designed to provide persons insured, restricted coverage paying benefits **ONLY** when certain losses occur as a result of specified disease. Coverage is not provided for basic hospital, basic medical-surgical, or major medical or comprehensive expenses.

HEART ATTACK OR STROKE LUMP SUM BENEFIT

We will pay a lump sum benefit, as shown below, if a covered person is diagnosed with a Heart Attack or Stroke after the Effective Date of coverage, subject to any Waiting Period, and while the policy is in force.

FIRST DIAGNOSIS BENEFIT: The First Diagnosis Lump Sum benefit is limited to one Lump Sum benefit amount during each covered person's lifetime under the Policy.

REOCCURRENCE BENEFIT: We will pay a Reoccurrence Benefit when a covered person experiences a Heart Attack or Stroke at least one full year after payment of the First Diagnosis Lump Sum Benefit under this Policy.

The Reoccurrence Benefit is a percentage of the First Diagnosis Lump Sum benefit amount (10% to 100%) and is based upon the number of years between the prior Heart Attack or Stroke event and the year the subsequent Heart Attack or Stroke event occurs / reoccurs. Benefits payable under this provision are subject to the Covered Person being free of treatment (except for maintenance medication(s) and follow-up examinations) for at least one full year prior to the reoccurrence.

CORONARY ANGIOPLASTY OR CORONARY ARTERY BYPASS SURGERY BENEFIT: This benefit is payable when a covered person undergoes a Coronary Angioplasty or Coronary Artery Bypass Surgery. To be eligible for this benefit:

- a. Medical advice to undergo Coronary Angioplasty or Coronary Artery Bypass Surgery must be received after the rider's effective date;
- b. Coronary Angioplasty or Coronary Artery Bypass Surgery must be performed while insured under this rider; and
- c. Coronary Angioplasty or Coronary Artery Bypass Surgery must not be performed as a direct result of a Heart Attack which immediately preceded the procedure or surgery.]

This policy is subject to a pre-existing condition limitation. A pre-existing condition is a condition for which: (a) medical advice or treatment was recommended by, or received from, a doctor within the 24-month period before the effective date of the covered person's coverage; or (b) symptoms existed which would have caused an ordinarily prudent person to seek diagnosis, care or treatment within the 24-month period before the effective date of the covered person's coverage.

[OPTIONAL BENEFIT RIDERS]

[**THERAPY AND WELLNESS BENEFIT RIDER:** This rider pays an indemnity benefit for specified health and wellness screenings. The benefit is limited to one payment per calendar year per covered person. The rider also provides benefits for therapy (physical, speech, hearing and occupational), educational services, mental health, healthy lifestyle programs and alternative care.]

[**INTENSIVE CARE BENEFIT RIDER:** This rider pays an indemnity benefit for confinement in an intensive care unit due to injury or sickness. A benefit of 50% for a step down unit is available. The benefit is doubled if confinement is due to and within 48 hours of an accident. **This rider is subject to a 30-day waiting period limitation.** This means rider benefits are payable when an intensive care confinement begins at least 30 days after a covered person's effective date of coverage.]

[**RETURN OF PREMIUM BENEFIT RIDER** (*Payable Upon Completion of Specified Return of Premium Period*): This rider may provide a return of premium benefit in the event your policy remains in force for [15] [20] [25] full years. The actual amount of premium that will be returned, if any, will be equal to 100% of all premiums you paid for the policy and any other benefit riders attached to the policy (unless expressly excluded), while this rider was in force (except for any application or annual policy fee) MINUS all benefits paid or then payable under the policy for you or any dependent(s). NOTE: The sum of all premiums is without interest accumulation.

At the end of the Return of Premium Period, you will have the option of renewing this rider. Renewal is conditioned upon the new Return of Premium Period beginning before your attained age 80.]

[**RETURN OF PREMIUM UPON DEATH BENEFIT RIDER:** The rider provides for a return of premium in the event of your death within 10 years of this rider's effective date, or death occurring prior to your age 85, whichever is later. The actual amount of premium that will be returned, if any, will be equal to 100% of all premiums you paid for the policy and any other benefit riders attached to the policy (unless expressly excluded), while this rider was in force (except for any application or annual policy fee) MINUS all benefits paid or then payable under the policy for you or any dependent(s). NOTE: The sum of all premiums is without interest accumulation.]

POLICY EXCLUSIONS

We will not pay a benefit for:

1. Heart Attack or Stroke if first diagnosed before the effective date of the covered person's coverage under the policy;
2. Coronary Angioplasty or Coronary Artery Bypass Surgery where medical advice to undergo such procedure or surgery was received before the policy's effective date; or
3. Any loss due to injury, disease or incapacity, unless related to or attributable to Heart Attack or Stroke.

[The following are exclusions that apply to the optional benefit riders.]

[Therapy and Wellness AND] [Intensive Care Benefit Riders]

1. [Intentionally self-inflicted Injury, violating or attempting to violate any duly enacted law.
2. Injury by acts of war, whether declared or not.
3. Attempted suicide while sane or insane.
4. Injury sustained while committing or attempting to commit a felony.
5. Injury sustained while voluntarily participating in a riot, or civil commotion or disturbance of any kind.
6. Loss of resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state in which the injury occurs.
7. Loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a doctor.]

WAITING PERIOD - There is a 30 day waiting period before we will pay benefits for a loss covered by the policy and attached riders. We will not pay benefits for covered conditions diagnosed or procedures performed during the waiting period.

RENEWABILITY - You may keep the policy and riders, if attached, in force during your entire lifetime by paying premiums when due or within the grace period. We cannot cancel or refuse to renew the policy or place any restrictions on it if you pay your premiums on time.

PREMIUMS ARE SUBJECT TO CHANGE - We may change your premium rates by giving you at least 31 days prior written notice. We can change the premium this way only if we change it on a class basis for all policies and riders of this class in your state.

INITIAL PREMIUM

COVERAGE DESCRIPTION	BENEFIT (AMOUNT/UNITS/TERM)	PREMIUM
Heart Attack or Stroke Lump Sum Benefit	Amount: \$ _____	\$ _____
[Return of Premium Benefit Rider	<input type="checkbox"/> [15] [20] [25] Years <input type="checkbox"/> [Upon Death]	\$ _____]
[Intensive Care Benefit Rider	Units: _____	\$ _____]
[Therapy & Wellness Benefit Rider	Units: _____	\$ _____]
Annual Policy Fee:		\$ 20.00
TOTAL ANNUAL PREMIUM: \$ _____		

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 and therefore, removing them from this outline of coverage.

Guarantee Trust Life Insurance Company

Statement of Variability For:

Outlines of Coverage OCG1130A and OCG1131A

(The outlines include previously approved benefit riders: RG11LSHAS (Lump Sum Heart Attack or Stroke) RG10CTW (Therapy and Wellness); RG10IC (Intensive Care); RG10ROP15, RG10ROP20, RG10ROP25 (Return of Premium after 15, 20, or 25 specified period); RG10ROPD (Return of Premium Upon Death))

The bracketing of variable text in Outlines OCG1130A and OCG1131A is limited to the following:

Outline of Coverage Forms OCG1130A and OCG1131A

1. The following riders and their respective benefit summaries and annual premium are optional and may be included within the outlines, or removed dependent upon the Company's marketing plan:
 - a. Heart Attack or Stroke Lump Sum Benefit Rider (Form RG11LSHAS)
 - b. Therapy and Wellness Benefit Rider (Form RG10CTW)
 - c. Intensive Care Benefit Rider (Form RG10IC)
 - d. 15-Year Return of Premium Benefit Rider (Form RG10ROP15)
 - e. 20-Year Return of Premium Benefit Rider (Form RG10ROP20)
 - f. 25-Year Return of Premium Benefit Rider (Form RG10ROP25)
 - g. Return of Premium Upon Death Benefit Rider (Form RG10ROPD)

Applications: APPH3-12 and APPH3-12-N/S

Application APPH3-12 and APPH3-12-N/S

2. Section B –
 - a. Plan Type – Limited to the following: Individual, Single Parent, Couple, or Family.
 - b. Coverage (items 2 through 7): Dependent upon the Company's marketing plan: (a) either or both policy forms (Lump Sum Cancer and Lump Sum Heart Attack or Stroke) will be made available; (b) all benefit riders shown are variable, which means the Company reserves the right to include or remove their availability.
 - c. Premium Payment Mode: Effective Date, Draft Date. Variability of mode payment is limited to: Annual, Semi-Annual, Quarterly and Monthly. Variability of payment method (other than direct bill) is limited to bank draft and credit card.

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



Joan Jannotta, Product Approval and Compliance
Guarantee Trust Life Insurance Company
November 20, 2012