GAP 5+

INCLUDED IN THIS PDF IS:

ATTENTION PLEASE

READ CAREFULLY FOR ALL LIMITATIONS, EXCLUSIONS, AGE LIMITS, DEFINITIONS AND SCHEDULE OF BENEFITS. CALL 866-438-4274 WITH ANY QUESTIONS.

WYOMING

(804/805)

GTL GUARANTEE TRUST LIFE

UBA

CERTIFICATES OF INSURANCE

GAP5+

Policy Form Series-MP-1400_804/805_v0623

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

CERTIFICATE OF INSURANCE

This is Your Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a contract between the Policyholder and Us. The Policyholder is shown on the Schedule of Benefits.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions and limitations of the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

Right to Examine: If You are not satisfied with this Certificate, return it to Our home office within ten days after the date You received it. This Certificate will then be canceled and any Premium paid will be refunded.

The Policy is held by the Policyholder. You may inspect it at any time during business hours at the office of the Policyholder.

READ YOUR CERTIFICATE CAREFULLY

Secretary

President

GROUP ACCIDENT ONLY COVERAGE

NON-PARTICIPATING

THIS IS A LIMITED BENEFIT ACCIDENT ONLY CERTIFICATE AND IS NOT CONSIDREED MINIMUM ESSENTIAL COVERAGE UNDER THE AFFORDABLE CARE ACT (ACA)

Table of Contents

Definitions

Accident: A sudden, unintended and unforeseeable, external event to the Covered Person which results in an Injury.

Ground Ambulance: Means a vehicle which is licensed solely as an ambulance by the local regulatory body to provide transportation of a Covered Person as a result of a Covered Accident to a Hospital or transportation from one Hospital to another for a Covered Person who is unable to travel to receive medical care by any other means.

Benefit Percent: The percentage of Covered Charges We pay for each Injury. The Benefit Percent is shown in the Schedule of Benefits.

Benefit Period: The number of days following the date of an Injury during which Covered Charges must be incurred, subject to the Initial Treatment Period. The Benefit Period begins on the date of the Injury and ends on the last day of the Benefit Period. The Benefit Period is shown on the Schedule of Benefits.

Commuting to/from Work: Traveling directly to the place of work (including temporary work sites) where a Covered Person is regularly employed from the Covered Person's Residence; or traveling directly from the place (including temporary work sites) where the Covered Person is regularly employed to the Covered Person's Residence.

Company: Guarantee Trust Life Insurance Company, a mutual company. Also hereinafter referred to as We, Us and Our.

Covered Charge: The Reasonable and Customary charge incurred for a service or supply listed in this certificate which is performed or given under the direction of a Doctor for the Medically Necessary treatment of an Injury . A Covered Charge is considered incurred on the date the treatment or service is rendered or the supply is furnished.

Covered Person: A person:

- Who is eligible for coverage as the Covered Person;
- Who has been accepted for coverage or has been automatically added;
- Who has paid the required premium; and
- Whose coverage has become effective and has not terminated.

Deductible: A dollar amount of Covered Charges a Covered Person must pay before We pay any benefits under the Policy. The Deductible is shown on the Schedule of Benefits.

Dependent: A person who is a Covered Person's:

- Legally married spouse and residing with the Covered Person. For purposes of this Policy, spouse also includes a common law marriage partner, domestic partner, or civil union partner if legally recognized in the governing jurisdiction.
- Child who is dependent upon the Covered Person for support and maintenance and is under the age of 26;
- Child who is dependent upon the Covered Person for support and maintenance, and is incapable of self-sustaining employment by reason of mental or physical handicap.

The term child refers to a Covered Person's unmarried:

- Natural child;
- Stepchild or foster child; A stepchild is a Dependent on the date a Covered Person married the child's parent.
- Adopted child, including a child placed with the Covered Person for the purpose of adoption, from the moment of placement as certified by the agency making the placement.

Doctor: A legally qualified person licensed in the healing arts and practicing within the scope of his or her license and who is not a Covered Person or a Family Member.

Durable Medical Equipment: A device which:

- is primarily and customarily used for medical purposes and is specially equipped with features and functions that are generally not required in the absence of Injury;
- is used exclusively by a Covered Person;
- is routinely used in a Hospital but can be used effectively in a non-medical facility;
- can be expected to make a meaningful contribution to a Covered Person's Injury; and
- Is prescribed by a Doctor and the device is Medically Necessary for a Covered Person's rehabilitation.

Durable Medical Equipment does not include:

- comfort and convenience items;
- equipment that can be used by Family Members other than a Covered Person;
- health exercise equipment; and
- equipment that may increase the value of a Covered Person's Residence.

Such items that do not qualify as Durable Medical Equipment include, but are not limited to: modifications to a Covered Person's Residence, property or automobiles, such as ramps, elevators, spas, air conditioners and vehicle hand controls; or corrective shoes, exercise and sports equipment.

Eligible Person: A member of the Policyholder's organization as defined on the Schedule of Benefits.

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

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

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

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

accordance with the drug, device or medical care at the time the expense is incurred.

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

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

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

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

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

Initial Treatment Period: The number of days following an Injury during which a Covered Person must seek initial treatment for an Injury. The Initial Treatment Period is shown on the Schedule of Benefits.

Injury: Bodily injury due to a covered Accident which:

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

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

Medically Necessary: A medical service, procedure or supply provided for the purpose of preventing, diagnosing or treating an illness, injury, disease or symptom and is a service, procedure or supply that:

- Is medically appropriate for the symptoms, diagnosis or treatment of the condition, illness, disease or injury;
- Provides for the diagnosis, direct care and treatment of the patient’s condition, illness, disease or injury;
- Is in accordance with professional, evidence based medicine and recognized standards of good medical practice and care; and
- Is not primarily for the convenience of the patient, physician or other health care provider.

Other Valid and Collectible Insurance or Plan: Any reimbursement for or recovery of any element of Covered Charges incurred by the Covered Person available from any other source whatsoever, except gifts and donations, but including without limitation:

- any individual, group, blanket, or franchise policy of accident, disability or health insurance;
- any arrangement of benefits for members of a group, whether insured or uninsured;
- any prepaid service arrangement such as Blue Cross or Blue Shield; individual or group practice plans, or health maintenance organizations;
- any amount payable for Hospital, medical or other health services. Injury arising out of a motor vehicle accident to the extent such benefits are payable under any medical expense payment provision (by whatever terminology used including such benefits mandated by law) of any motor vehicle insurance policy.
- any amount payable for services or injuries or diseases related to a Covered Person's occupation to the extent that the Covered Person actually received benefits under a Worker's Compensation Law or if the Covered Person enters into a settlement to give up his or her rights to recover future medical expenses

that would have been payable except for that settlement;
- Social Security Disability Benefits, except that Other Valid and Collectible Insurance or Plan shall not include any increase in Social Security Disability Benefits payable to the Covered Person after the Covered Person becomes disabled while insured hereunder.
- any benefits payable under any program provided or sponsored solely or primarily by any governmental agency or subdivision or through operation of law or regulation.

Physical Therapy: Non-surgical physical or mechanical therapy, diathermy, ultrasonic therapy, heat treatment in any form, manipulation or massage.

Policyholder: The entity to which the Policy is issued.

Prescription Drugs: Drugs which may only be dispensed by written prescription under Federal law, and approved for general use by the Food and Drug Administration. The drugs must be dispensed by a licensed pharmacy provider for a Covered Person's outpatient use.

Reasonable and Customary Charges, Fees or Expenses: The most common charge for similar professional services, drugs, procedures, devices, supplies or treatment within the area in which the charge is incurred, so long as those charges are reasonable. The most common charge means the lesser of:
- the actual amount charged by the provider;
- the negotiated rate; or
- the charge which would have been made by the provider (Doctor, Hospital, etc) for a comparable service or supply made by other providers in the same Geographic Area as reasonably determined by us for the same service or supply.

"Geographic Area" means the three digit zip code in which the service, treatment, procedure, drugs or supplies are provided; or a greater area if necessary to obtain a representative cross-section of charge for a like treatment, service, procedure, device drug or supply.

Residence: The home and land or property on which a Covered Person's dwelling or home is located.

You, Your and Yours: The person to whom this certificate is issued and whose insurance is in force under the terms of the Policy.

CONDITIONS OF INSURANCE

ELIGIBILITY

Eligible Persons are described in the Schedule of Benefits. A person is insured under the Policy provided such person satisfies the eligibility requirements, becomes insured and remains insured under the terms of the Policy.

EFFECTIVE DATE

Covered Person: Coverage is effective, subject to receipt of premium, on the date agreed to by the Policyholder and Us.

Dependents Acquired After Effective Date:
- **Newborn Child:** A Covered Person’s newborn child is automatically covered from the moment of birth until such child is 31 days old. Coverage for such child will be for an Injury. However, the Covered Person must notify Us in writing within 31 days of such birth and pay the required additional premium, if any, in order to have coverage for the newborn child continue beyond such 31 day period.

- **Adopted Child:** Coverage for an adopted child is effective upon the earlier of the date of placement for the purpose of adoption or the date of entry of an order granting the adoptive parent custody of the child for purposes of adoption. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. Coverage for such child will be for Injury. However, the Covered Person must notify Us in writing within 31 days of such adoption and pay the required additional premium, if any, in order to have coverage for the adopted child continue beyond such 31 day period.
- **Other Than Newborn or Adopted Child:** A person who qualifies as a Dependent after the Effective Date of coverage may be insured under the Policy. Enrollment and premium must be received by Us within 31 days after the date the person first qualifies as a Dependent, and the required premium must be paid. Coverage is effective upon receipt of enrollment and premium by Us at Our Home Office.

TERMINATION

Covered Person: Coverage will terminate at the earlier of:

- the date the Policy terminates;
- the date the Covered Person ceases to be an Eligible Person;
- the end of the period for which any applicable premium has been paid by the Policyholder on behalf of the Covered Person;
- the date of fraud or misrepresentation of a material fact by a Covered Person;

SCOPE OF COVERAGE

Please see the Scope of Coverage section in a Covered Person's Schedule of Benefits. There a Covered Person will find which of the following types of Accident coverage apply to the Covered Person’s benefit plan.

24-Hour-A-Day Accident Coverage: A Covered Person is covered for Injury which is incurred on a 24-hour per day basis.

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

If, within 365 days from the date of a covered Accident, Injury from such covered Accident results in a loss covered by this benefit, We will pay the benefit in the amount set opposite such loss, as shown on the Schedule of Benefits. If a Covered Person sustains more than one such loss as the result of the covered Accident, We will pay only one amount, the largest to which a Covered Person is entitled.

Loss of hand or foot means loss by severance at or above the wrist or ankle joint. Loss of sight means the total, permanent loss of sight of the eye. The loss of sight must be irrecoverable by natural, surgical or artificial means. Loss of speech means total, permanent and irrecoverable loss of audible communication. Loss of hearing means total and permanent loss of hearing in both ears which cannot be corrected by any means. Loss of a thumb and index finger means complete severance through or above the metacarpophalangeal joints (the joints between the fingers and the hand). Severance means the complete separation and dismemberment of the part from the body.

ACCIDENT MEDICAL EXPENSE BENEFITS

After the Deductible has been satisfied We will pay benefits, as defined and limited below, for Covered Charges incurred by a Covered Person due to Injury caused by a covered Accident.

Covered Charges are payable only for an Injury:

- for which the first treatment or service is incurred within the Initial Treatment Period; and
- for which expense for all treatment or service is incurred within the Benefit Period.

Covered Charges are shown on the Schedule of Benefits.

No Other Valid and Collectible Insurance or Plan

We will pay the Benefit Percent of incurred Covered Charges up to the Maximum Benefit Amount, Per Injury, subject to the definitions, limitations, exclusions and other provisions of the Policy.

Other Valid and Collectible Insurance or Plan

After the Deductible has been satisfied, We will pay the Benefit Percent of incurred Covered Charges which are in excess of the total benefits payable for the same Injury by any Other Valid and Collectible Insurance or Plan on a provision of service or on an expense incurred basis, up to the Maximum Benefit Amount, Per Accident. Benefit payment is subject to the definitions, limitations, exclusions and other provisions of this Certificate.

A Covered Person must provide Us with proof of the amount of benefits paid by Other Valid and Collectible Insurance or Plan or proof of denial of benefits by Other Valid and Collectible Insurance or Plan.

If, for any reason, a Covered Person fails to apply for benefits from Other Valid and Collectible Insurance or Plan, We will pay the benefit that would have been paid under the Policy had the Covered Person filed a claim under the Other Valid and Collectible Insurance or Plan.

If Other Valid and Collectible Insurance or Plan provides benefits on an excess coverage basis, benefits will be paid first by the company or services plan whose policy or service contract has been in effect for the longer period of time at the date of the Injury.

Exclusions

The Policy does not provide benefits for:

- Treatment, services or supplies
    - Are not Medically Necessary;
    - Are not prescribed by a Doctor as necessary to treat an Injury;
    - Are determined to be Experimental/Investigational in nature;
    - Are received without charge or legal obligation to pay;
    - Are received from persons employed or retained by any Family Member, unless otherwise specified; or
    - Are not specifically listed as Covered Charges in the Policy.
- Injury by acts of war, whether declared or not.
- Injury received while traveling or flying by air, except as a fare-paying passenger and not as a pilot or crew member, on a regularly scheduled commercial airline.
- Injury covered by Worker’s Compensation, Employer Liability law or Occupational Disease Act or Law.
- Dental treatment, except as specifically stated.
- Injury sustained while committing or attempting to commit a felony.
- Prescription Drugs except as specifically stated.
- Suicide or attempted suicide while sane or insane.
- Intentionally self-inflicted Injury.
- Loss resulting from being legally intoxicated or under the influence of alcohol as defined by the laws of the state or jurisdiction in which the Injury occurs.
- Loss resulting from being under the influence of any drugs or narcotic unless administered on the advice of a Doctor.
- Injury sustained while participating in or practicing for any professional, intercollegiate or club sports

activity, except as specifically provided.
- Injury which occurs while a Covered Person is on active duty service in any armed forces. Reserve or National Guard active duty for training is not excluded unless it extends beyond 31 days.
- Injury sustained flying in an ultra-light, hang gliding, parachuting or bungee-cord jumping, by flight in a space craft or any craft designed for navigation above or beyond the earth's atmosphere.
- Injury sustained while driving or riding on vehicles for off-road use including but not limited to all-terrain vehicles (ATV's).
- Injury sustained where a Covered Person is the operator and does not possess a current and valid motor vehicle operator's license, except in a Driver's Education Program.
- Treatment in any Veteran's Administration or federal Hospital, except if there is a legal obligation to pay.
- Cosmetic surgery, except for reconstructive surgery on an injured part of the body.
- Covered Charges incurred outside of the United States or its possessions.
- Competing in motor sports races or competitions;
- Competing in water sports races or competitions;
- Testing cars/trucks on any racetrack or speedway;
- Handling, storing or transporting explosives;
- Scaling up cliffs or mountain walls;
- Spelunking (exploring caves);
- Handling or working with dangerous animals.
- Injury sustained while water skiing or surfboarding;
- Injury sustained while snow skiing or snowboarding;
- Injury sustained while roller blading or skateboarding;
- Injury sustained while participating in a rodeo.
- Reinjury or complications of an Injury caused or contributed to by a condition that existed Before the Accident.
- Repetitive motion injuries, strains, hernia, tendonitis, bursitis and heat exhaustion not related to a specific Injury.

CLAIM PROVISIONS

Notice of Claim: Written notice of claim must be given to the Company or its authorized representative within 60 days after a covered loss starts, or as soon thereafter as is reasonably possible. Notice should include information sufficient to identify the Covered Person.

Claim Forms: The Company, upon receipt of written notice of claim, will furnish to the claimant such forms as are usually furnished by it for filing Proofs of Loss. If such forms are not furnished within 15 days after the giving of such notice, the claimant shall be deemed to have complied with the requirements of the Policy as to Proof of Loss upon submitting, within the time fixed in the Policy for filing Proof of Loss, written proof covering the occurrence, the character, and the extent of the loss for which claim is made.

Proof of Loss: Written proof of loss for Hospital confinement must be given to the Company or its authorized representative within 90 days after release from the Hospital. Proof of any other covered loss must be given to the Company or its authorized representative not later than 90 days after the covered loss. If proof of loss is not given within the time specified, the claim will not be denied or reduced for that reason if that proof was given as soon as reasonably possible.

Time of Payment of Claims: Benefits will be paid as soon as We receive proper proof of loss unless the Policy provides for periodic payment. When the Policy provides for periodic payment, the benefits will accrue and will be paid monthly subject to proper proof of loss.

Payment of Claims: Benefits payable under the Policy for a Covered Person's loss of life will be paid at Our option, to the Covered Person's next of kin or to the Covered Person's estate. All other benefits will be payable to the Covered Person or the medical services provider if We have received a valid assignment by the Covered Person.

Subject to a Covered Person's written direction or of a Covered Person's legal or natural guardian if a Covered Person is a minor or otherwise incompetent to make such a direction, all or a portion of any indemnities provided by the Policy as a result of medical, surgical, dental, hospital or nursing service may, at the Company's option, and unless the Company is requested in writing not later than the time for filing proofs of loss, be paid directly to the hospital or person rendering such services.

Change of Beneficiary: A Covered Person has the right to change the beneficiary and the consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

Physical Examination and Autopsy: The Company, at its own expense, shall have the right and opportunity to examine a Covered Person as it may reasonably require while a claim is pending. The Company, at its own expense, may also have the right to make an autopsy in the case of death, where it is not prohibited by law.

Legal Actions: A legal action may not be brought to recover on the Policy within 60 days after written Proof of Loss has been given as required. No such action may be brought after 3 years from the time written proof was required to be given.

Subrogation: When benefits are paid to or for a Covered Person under the terms of the Policy, We shall be subrogated, unless otherwise prohibited by law, to a Covered Person's rights of recovery against any person who might be acknowledged liable or found legally liable by a Court of competent jurisdiction for the Injury that necessitated the hospitalization or the medical or surgical treatment for which benefits were paid. Such subrogation rights shall extend only to the recovery by the Company of the benefits it has paid for such hospitalization and treatment and the Company shall pay fees and costs associated with such recovery.

GENERAL PROVISIONS

Entire Contract; Changes: The Policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by an executive officer of the Company and unless such approval be endorsed hereon or attached hereto. No agent has authority to change the Policy or waive any of its provisions.

Failure by the Company to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.

Non-Participating: The Policy is non-participating. It does not share in the Company's profits or surplus earnings.

Workers' Compensation: This Certificate is not in lieu of and does not affect any requirement for coverage by Workers' Compensation Insurance.

Conformity With State Statutes: If any provision of the Policy is contrary to any law to which it is subject, such provision is hereby amended to conform to the minimum requirements of such law.

INTERNAL APPEAL OF A CLAIM DENIAL AND AN INDEPENDENT EXTERNAL REVIEW

DEFINITIONS

Adverse Determination: A determination by Us or Our designee utilization review entity that an admission, availability of care, continued stay or other health care service has been reviewed and, based upon the information provided, does not meet Our requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness, and the requested service is therefore denied, reduced, or terminated.

Appeal: A formal process whereby an insured, a representative of an insured, attending physician, facility or health care provider can contest an Adverse Determination rendered by Us or Our designee utilization review

organization, which results in denial, reduction or termination of a requested health care service.

Claim Denial: Any of the following: a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit, including any such denial, reduction, termination, or failure to provide or make payment that is based on a determination of a participant's or beneficiary's eligibility to participate in a plan, and including, with respect to group health plans, a denial, reduction, or termination of, or a failure to provide or make payment (in whole or in part) for, a benefit resulting from the application of any Utilization Review, as well as a failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not Medically Necessary or appropriate.

Grievance: A written complaint submitted by or on behalf of an insured regarding the:

- Availability, delivery, or quality of health care services, including a complaint regarding an Adverse Determination made pursuant to Utilization Review;
- Claims payment, handling, or reimbursement for health care services; or
- Matters pertaining to the contractual relationship between an insured and Us.

Utilization Review: A set of formal techniques designed to monitor the use of or evaluate the clinical necessity, appropriateness, efficacy, or efficiency of health care services procedures, providers, or facilities. Techniques and methods may include ambulatory care review, case management, concurrent hospital review, discharge planning, pre-hospital admission certification, pre-inpatient service eligibility certification, prospective review, second opinion, or retrospective review.

INTERNAL APPEAL PROCESS

In the event of an Adverse Determination, an insured shall have a reasonable opportunity to Appeal a Claim Denial by submitting a Grievance to Us. There shall be a full and fair review of each Claim Denial. Full and fair review shall require that:

- The insurer will provide to the claimant, a complete explanation of the basis for the decision and shall specify why the services, procedures or supplies requested are not Medically Necessary.
- The insurer will provide to the claimant a statement indicating the claimant’s right to have the insurer’s decision reviewed by health care professionals who have no association with the insurer and is not the attending physician or the physician’s partner by following the procedures outlined in the Appeal Process.
- The claimant shall have at least 60 days following receipt of a notification of a Claim Denial to Appeal.

RIGHT TO FILE AN INDEPENDENT EXTERNAL APPEAL

1. Within sixty (60) days of receiving the written explanation of denial from the insurer, a claimant may request an external review of the decision by filing a written request for such review. The request shall be submitted to the insurer on a form approved by the commissioner, unless such form was not provided to the claimant in which event any written request for an external review shall be sufficient.
2. Upon receiving a request for external review, the insurer shall:
    a. Immediately send a copy of the request to the commissioner;
    b. Assign the request to an independent review organization that has been approved by the commissioner for a preliminary review. The insurer shall provide to the independent review organization all documents and information upon which the insurer relied in denying all claims under review. Failure to provide the documents and other information shall not delay the conduct of the external review. The independent review organization shall determine whether:
        i. The claimant is or was a Covered Person in the disability insurance policy at the time the provision of or payment for medical services, procedures or supplies was requested or provided;
        ii. The provision of or payment for medical services, procedures or supplies requested by the claimant reasonably appears to be a covered service under the disability insurance policy,

but for the determination by the insurer that the services, procedures or supplies are not a medical necessity;

iii. The insurer has denied the claimant's request for the provision of or payment for medical services, procedures or supplies after having been given the opportunity to review the insurer's first denial one (1) or more times;

iv. The claimant has provided to the insurer all the information and forms required to process an external review, including a release form, approved by the commissioner, by which the claimant authorizes the release of protected health information pertinent to the external review.

3. The independent review organization shall within five (5) days determine whether the documentation is complete and immediately notify the claimant and the insurer in writing whether the documentation is complete and, if not, what information or documentation is missing. The claimant may submit in writing to the independent review organization any additional supporting documentation that the independent review organization should consider or may require when conducting its external review. If the request for review is not complete, the independent review organization shall require from the insurer or the claimant the information or materials needed to make the request complete.
4. All documentation or other information provided to the independent review organization by the insurer or claimant shall also be immediately provided to the adverse party by the independent review organization. The insurer may use any documentation or other information provided by the claimant to reconsider its settlement of the claims. If the insurer chooses to reverse its prior decision, it shall immediately provide written notice to the claimant, the independent review organization and the commissioner, at which time the review shall be terminated.
5. The independent review organization shall consider the following in reaching its decision:
    a. The claimant's medical records;
    b. The attending health care professional's recommendation;
    c. Consulting reports from appropriate health care professionals and other documents submitted by the insurer, claimant or the claimant's treating provider;
    d. The terms of coverage under the claimant's disability insurance policy;
    e. The standards identified as Medically Necessary;
    f. All evidence based research used in the insurer's denial of the claim.
6. Within forty-five (45) days after the date of receipt of the request for external review, the assigned independent review organization shall provide written notice to the claimant, the insurer and the commissioner of its decision to uphold or reverse the decision of the insurer that the provision of or payment for medical services, procedures or supplies requested by the claimant are not Medically Necessary. Such written notice shall include:
    a. A general description of the reason for the request for external review;
    b. The date the independent review organization received the assignment from the insurer to conduct the review;
    c. The date the external review was conducted;
    d. The date of its decision;
    e. The principal reasons for its decision;
    f. The rationale for its decision; and
    g. References to the evidence or documentation considered in reaching its decision.
7. In the event the external review organization determines the claims should be allowed, the insurer shall approve the request for the provision of or payment for medical services, procedures or supplies that was the subject of the review and notify the claimant of such approval within five (5) days.
8. The engagement by an insurer of an independent review organization to conduct an external review in accordance with this section shall be fair and impartial. The insurer, insured and the independent review organization shall comply with regulations promulgated by the commissioner to ensure fairness and impartiality in the engagement of approved independent review organizations, in the terms, termination and payment of independent review organizations and in the review process.
9. The commissioner shall adopt regulations establishing an expedited review by an external review organization as expeditiously as the claimant's medical condition or circumstances require, but in no event more than seventy-two (72) hours after the date of receipt of the request for an expedited external review, and which allows an expedited external review where:
    a. The timeframe for the completion of a normal external review would seriously jeopardize the life

or health of the claimant or would jeopardize the claimant's ability to regain maximum function; or

b. The claimant's claim concerns a request for an admission, availability of care, continued stay or health care service for which the claimant received emergency services, but has not been discharged from a health care facility.

10. The insurer against whom a request for external review is filed shall pay the costs of the independent review organization's external review.

SCHEDULE OF BENEFITS

Policyholder:	United Business Association
Policy Effective Date:	April 1, 2023
Eligible Persons:	Persons who are members of an eligible Class as defined by the Policyholder and agreed to by Us. Eligible Classes are: Class 1: Eligible members of United Business Association who are under age 65. Class 2: Enrolled eligible dependent spouses under age 65 and eligible children of Class 1.
Scope of Coverage:	24-HOUR-A-DAY ACCIDENT COVERAGE

ACCIDENTAL DEATH AND DISMEMBERMENT, LOSS OF SIGHT, SPEECH AND HEARING BENEFIT

The Principal Sum	$ 2,500.00 *
Loss of Life	$ 2,500.00
Loss of Both Hands	$ 2,500.00
Loss of Both Feet	$ 2,500.00
Loss of the Entire Sight of Both Eyes	$ 2,500.00
Loss of One Hand and One Foot	$ 2,500.00
Loss of Speech and Hearing	$ 2,500.00
Loss of One Hand or One Foot and Entire Sight of One Eye	$ 2,500.00
Loss of One Hand or One Foot	$ 1,250.00
Loss of Entire Sight of One Eye	$ 1,250.00
Loss of Speech or Hearing	$ 1,250.00
Loss of Hearing in One Ear	$ 625.00
Loss of Thumb and Index Finger of the Same Hand	$ 625.00
*Principal Sum will be reduced by 50 % for Injury which occurs on or after a Covered Person's 65 th birthday.	

ACCIDENT MEDICAL EXPENSE BENEFITS

Maximum Amount Per Accident.	$ 5,000.00
Benefit Percent.	100%
Deductible Per Accident.	$ 100.00
Initial Treatment Period.	60 days
Benefit Period.	12 months

COVERED CHARGES

Treatment, services or supplies incurred for:	**Maximum Amount**
Hospital room and board, and general nursing care.	Up to Policy Limits
Hospital miscellaneous expense.	Up to Policy Limits
Doctor’s fees for surgery.	Up to Policy Limits
Anesthesia services.	Up to Policy Limits
Doctors’ visits, inpatient and outpatient.	$ 75.00
Hospital Emergency care Includes all items of expense.	$ 500.00
Ambulance expense.	$ 250.00
X-ray and other diagnostic tests.	$ 250.00
Durable Medical Equipment.	$ 100.00
Prescription Drugs.	$ 500.00
Dental treatment for Injury to Sound Natural Teeth.	$ 250.00 per tooth up to a maximum of $ 500.00
Physical Therapy.	$ 60.00 for first visit; $ 30.00 for each visit thereafter
Registered Nurse expense.	Up to Policy Limits

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

THIS RIDER CONTAINS A PRE-EXISTING PERIOD

CANCER LUMP SUM BENEFIT RIDER

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

THIRTY (30) DAY RIGHT TO RETURN THIS RIDER

If the Covered Person is not satisfied with this Rider, he or she may return it to Us within thirty (30) days of its receipt. It may be returned to Us by mail or to the agent who sold it. We will then refund all premiums paid for this Rider and it will be void.

CANCER LUMP SUM BENEFIT DEFINITIONS

The following definitions and those applicable definitions contained in the Policy will apply wherever the terms are used in this Rider.

Benefit Eligibility Period for Pre-Existing Conditions means the period of time after the Effective Date of this Rider which must elapse before We will pay a benefit for a Pre-Existing Condition.

Cancer means a disease manifested by the presence of a malignancy characterized by the uncontrolled growth and abnormal spread of malignant cells and the invasion of body tissue by such malignant cells. Cancer includes Hodgkin's disease and leukemia. This definition excludes such cancers as:

1. Pre-malignant tumors or polyps;
2. Skin Cancer, except malignant melanoma; and
3. Cancer In Situ.

Cancer will not be a covered condition when advice or treatment is received within the Waiting Period, if any, or prior to the Effective Date, and such advice or treatment leads to the Diagnosis of Cancer. If tissue is extracted during the Waiting Period, if any, or prior to the Effective Date, and results in a Diagnosis of Cancer, this will not be a covered condition. 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 Diagnosis of Cancer after the Waiting Period, the Covered Person has the option to cancel the Rider and receive a refund of all premiums paid on this Rider. For the purposes of this Rider, the date of Diagnosis will be considered to be the earlier of the date of clinical Diagnosis or the date the specimen used to diagnose Cancer is taken.

Diagnosis/Diagnosed means the first time in which the earliest of the following occurs:

1. Cancer is initially Diagnosed by a pathologist. A pathological diagnosis must be based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or postmortem). The Doctor or Pathologist establishing the pathological diagnosis shall base his/her judgment solely on the malignancy after a study of the histocytologic architecture or suspect tumor, tissue or specimen.
2. Cancer is initially Diagnosed by clinical or non-pathological diagnosis, if diagnosis from tissue cannot be made, or where the patient has been advised by a Doctor that a diagnosis of Cancer

can be determined by clinical means. A clinical or non-pathological diagnosis of Cancer will only be accepted as an initial Diagnosis when it is not medically possible to attempt a pathological diagnosis. Proof that it is not medically possible to attempt a pathological diagnosis must be satisfactory to Us. We reserve the right to request additional information, an additional Doctor's or Pathologist's statement and/or examination by a Doctor or Pathologist of Our choice at Our expense.

Doctor, for the purposes of this Rider, means any licensed practitioner of the healing arts acting within the scope of his or her license in treating an injury or illness. It doesn't include the Covered Person or a Family Member.

Documented Medical Evidence includes but is not limited to appropriate radiology, diagnostic testing, laboratory testing, or physical examination by an Oncologist.

Oncologist means a Doctor, other than the Covered Person or Family Member, specializing in the diagnosis and treatment of Cancer.

Pathologist means a licensed Doctor, other than the Covered Person or a Family Member:

- Specializing in the interpretation and diagnosis of changes caused by disease in tissue.

Pre-Existing Condition: A pre-existing condition is a condition for which medical advice or treatment was recommended by, or received from a Doctor, within the 6 month period before the Policy Effective Date. A pre-existing condition is not covered unless the loss begins more than 12 months after the Policy Effective Date.

Positive Diagnosis (of Cancer) means a medical diagnosis of Cancer by a Doctor of Pathology. Diagnosis must be based on a microscopic examination of fixed tissue or preparations from the hemic system (either during life or postmortem.) We will accept a clinical diagnosis of Cancer when it is not medically possible to attempt a pathological diagnosis, or where the patient has been advised by a Doctor that a diagnosis of Cancer can be performed by clinical means. We reserve the right to request additional information, an additional Doctor's statement and/or examination by a Doctor of Our choice at Our expense.

Cancer will not be a covered condition when advice or treatment is received prior to the Effective Date, and such advice or treatment results in a Positive Diagnosis of Cancer. If tissue is extracted prior to the Effective Date, and results in a Positive Diagnosis of Cancer, this will not be a covered condition. The date of Positive Diagnosis is the earlier of the date of clinical Diagnosis or the date the specimen used to diagnose Cancer is taken.

Waiting Period means the number of days, if any, after this Rider's Effective Date before We will pay benefits for loss due to Cancer. If the Initial Diagnosis of Cancer is made during the Rider Waiting Period, the Covered Person has the option to cancel this Rider and receive a refund of all premiums paid.

BENEFIT PROVISIONS

Subject to all terms, conditions, definitions, limitations, exclusions, Waiting Period and other provisions of this Policy, benefits under this Policy are payable as follows:

Cancer Lump Sum Benefit: We will pay the Cancer Lump Sum Benefit if the Covered Person is Diagnosed with Cancer after this Rider's Effective Date of coverage and while this Rider is in force, subject to the Waiting Period, if any. The Cancer Lump Sum Benefit is shown in the Schedule of Benefits.

Benefits under this provision are limited to one (1) First Diagnosis Lump Sum Benefit payment per Covered Person's lifetime.

ELIGIBILITY FOR BENEFITS

CANCER DIAGNOSIS: In order for a benefit to become payable under the Policy, a Positive Diagnosis of Cancer must be performed in one of the following methods:

1. **Pathological Diagnosis:** A Diagnosis by a Pathologist from the results of a microscopic study of fixed tissue or blood samples.

2. **Clinical Diagnosis:** A clinical diagnosis based on the study of symptoms. We will accept a clinical diagnosis only when:
    a. A pathological diagnosis is detrimental to the patient's health, or where the patient has been advised by a Doctor that a diagnosis of Cancer can be determined by clinical means;
    b. There is medical evidence to support the diagnosis; and
    c. A Doctor is treating the patient for Cancer.

3. **Other Diagnosis:** Pathologic interpretation of the histology of skin lesions will be accepted from a dermatologist doctor. For lung Cancer, We will accept a cytology report in lieu of a pathology report.

PRE-EXISTING CONDITION LIMITATION

A Pre-Existing Condition is not eligible for benefits unless the Diagnosis occurs after this Rider Effective Date and the Waiting Period, if any, has expired. We will not pay benefits for a Pre-Existing Condition that is Diagnosed within the Pre-Existing Period stated in the Schedule of Benefits.

A Pre-Existing Condition is not covered unless the loss begins after the Benefit Eligibility Period for Pre-Existing Conditions has elapsed as stated in the Schedule of Benefits.

EXCLUSIONS

We will not pay benefits for:

1. A Positive Diagnosis of Cancer before the Effective Date of the Covered Person's coverage under the Policy;
2. Any loss due to injury, disease or incapacity, unless related to or attributable to Cancer as defined;
3. Any Cancer when advice or treatment is received during the Waiting Period or prior to the Effective Date, and such advice or treatment results in a Positive Diagnosis of Cancer. If tissue is extracted during the Waiting Period or prior to the Effective Date, and results in a Positive Diagnosis of Cancer, this will not be a covered condition. For the purposes of this Rider, the date of a Positive Diagnosis of Cancer will be considered to be the earlier of the date of clinical diagnosis or the date the specimen used to diagnose Cancer is taken. If a Positive Diagnosis of Cancer is made and/or Cancer is treated within the Waiting Period, OR if medical advice is given within the Waiting Period which leads to the subsequent Positive 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 Rider.

TERMINATION

This Rider will terminate on the earliest of:

1. The date the Policy to which this Rider is attached is terminated;
2. The date the Covered Person asks Us, in writing, to cancel this Rider;
3. The date the Covered Person attains age 65;
4. The date the Policy lapses for non-payment of premium; or
5. The date We have paid all benefits available under this Rider.

RENEWAL AND PREMIUM

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

This Rider requires the payment of premium in addition to the premium due for the Policy.

We can change the premium for this Rider if We change it for all riders like this one in the Covered Person's state on a class basis. Before any change in premium becomes effective, We will provide the Covered Person with advance written notice in the time stated in the Policy.

CONDITIONS

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

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

Secretary

President

CANCER LUMP SUM BENEFIT RIDER

SCHEDULE OF BENEFITS

RIDER EFFECTIVE DATE:	April 1, 2023
Eligible Persons:	Persons who are members of an Eligible Class as defined by the Policyholder and agreed to by Us. Eligible Classes are: All members of the Policyholder under age 60. Covered Person and Dependent Spouse coverage ends at age 65. Dependent child coverage ends at age 26 or as otherwise defined in the Certificate.
WAITING PERIOD:	30 days
MAXIMUM BENEFIT AMOUNT:	$ 5,000.00
PRE-EXISTING PERIOD:	6 Months
BENEFIT ELIGIBILITY FOR PRE-EXISTING CONDITIONS:	12 Months after the Rider Effective Date
PRE-EXISTING CONDITION: A pre-existing condition is a condition for which medical advice or treatment was recommended by, or received from a Doctor, within the 6 month period before the Policy Effective Date. A pre-existing condition is not covered unless the loss begins more than 12 months after the Policy Effective Date.	

GUARANTEE TRUST LIFE INSURANCE COMPANY
1275 Milwaukee Avenue, Glenview, Illinois 60025
(800-338-7452)

LIMITED SPECIFIED DISEASE BENEFIT RIDER
Providing Benefits for Heart Attack and Stroke

THIS RIDER CONTAINS A PRE-EXISTING PERIOD

This Rider is attached to and made a part of the Policy to which it is attached. It is issued in consideration of the application and payment of the required premium. This Rider takes effect on the Effective Date shown at 12:01 a.m. Standard Time where the Covered Person lives. If no date is shown, it begins on the Certificate Effective Date.

TEN (10) DAY RIGHT TO RETURN THIS RIDER

If the Covered Person is not satisfied with this Rider, he or she may return it to Us within ten (10) days of its receipt. It may be returned to Us by mail or to the agent who sold it. We will then refund all premiums paid for this Rider and it will be void.

DEFINITIONS

The following definitions and those applicable definitions contained in the Policy will apply wherever the terms are used in the Rider.

Benefit Eligibility Period for Pre-Existing Conditions means the period of time after the Effective Date of this Rider which must elapse before We will pay a benefit for a Pre-Existing Condition.

Covered Conditions means only Heart Attack or Stroke as defined in this Rider.

Diagnosis means the time in which the earliest of the following takes place:
1. A Heart Attack is diagnosed by a Doctor AND
2. A Heart Attack is evidenced by: (a) significant abnormal electrocardiographic (ECG) findings; and/or (b) clinical findings and cardiac blood enzyme abnormalities.
3. A Stroke is evidenced by a diagnostic picture of permanent neurological damage provided from Computer Axial Tomography (CAT scan), a Magnetic Resonance Image (MRI) and/or a Magnetic Resonance Angiograph (MRA).

Doctor, for the purposes of this Rider, means any licensed practitioner of the healing arts acting within the scope of his or her license in treating an injury or illness. It doesn't include the Covered Person, or a member of the Covered Person's Immediate Family.

Heart Attack means a myocardial infarction (irreversible injury and death of a portion of the heart muscle as a result of obstruction of one or more of the coronary arteries.) Diagnosis of a Heart Attack must be supported by three (3) or more of the following:
a. Typical clinical symptoms, such as central chest pain;
b. Diagnostic increase of specific cardiac markers;
c. New electrocardiographic (EKG) changes indicative of infarction;
d. Confirmatory imaging studies; or
e. In the event of death, an autopsy confirmation or a death certificate that indicates Myocardial Infarction as the primary cause of death will be accepted as evidence of a Heart Attack.

Heart Attack does not mean cardiac arrest, sudden cardiac arrest, coronary artery disease, congestive heart failure, atherosclerotic heart disease, angina, or any other dysfunction of the cardiovascular system. Heart Attack also does not mean a silent/old Heart Attack, which is a prior incidence of heart attack which has few, if any, symptoms and is generally discovered at a later date through imaging tests, such as electrocardiogram (EKG) or echocardiogram (ECG).

Pre-Existing Condition: A Pre-Existing Condition is a condition for which: (a) Medical advice or treatment was recommended by, or received from a Doctor, within the Pre-Existing Period shown in the Schedule; or (b) symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the Pre-Existing Period before the Effective Date of the Covered Person's coverage. Treatment includes being prescribed or taking prescription drugs or medicines.

A Pre-Existing Condition is not covered unless the loss begins after the Benefit Eligibility for Pre-Existing Conditions has elapsed.

Stroke means an acute cerebrovascular accident or incident, embolism, thrombosis or hemorrhage which results in paralysis or other measurable objective neurological deficit lasting more than 24 hours. A cerebrovascular accident is a sudden, unexpected interference in brain function caused by insufficient blood flow to part of the brain. Diagnosis must include imaging documentation of new brain tissue infarction in association with acute onset of symptoms consistent with central nervous system neurological damage.

For the purposes of this Rider, Stroke does not include:

1. Chronic cerebrovascular insufficiency;
2. Transient Ischemic Attacks (TIAs);
3. Transient Global Amnesia (TGA);
4. External trauma causing Accidental Injury to the brain;
5. Brain damage due to infection, vasculitis, encephalopathy and inflammatory disease; or
6. Ischemic disorders of the vestibular system.

Waiting Period means the number of days, if any, after this Rider's Effective Date before We will pay benefits for loss due to a Covered Condition. If the Diagnosis of a Covered Condition is made during the Rider Waiting Period, the Covered Person has the option to cancel this Rider and receive a refund of all premiums paid.

ELIGIBILITY FOR BENEFITS

After the Waiting Period, if any, has been satisfied and while the Policy and this Rider are in force for the Covered Person, We will pay the Lump Sum Benefit Amount shown in the Schedule upon the diagnosis of a Covered Condition.

If more than one qualifying Covered Condition occurs or procedure is performed under the Additional Benefit provision, a benefit will only be provided for the first Covered Condition or Additional Benefit that is eligible for benefits. A benefit will not be provided for multiple conditions.

Benefits are payable provided the following requirements are met:

1. The Diagnosis is made while this Rider is in force; and
2. The Diagnosis is not the result of or related to a Pre-Existing Condition;
3. The Diagnosis is made after the expiration of the Waiting Period, if any, and
4. All terms and conditions of the Policy and this Rider have been met.

This Rider is subject to the Maximum Benefit Amount.

PRE-EXISTING CONDITION LIMITATION

A Pre-Existing Condition is not eligible for benefits unless the Diagnosis occurs after this Rider Effective Date and the Waiting Period, if any, has expired. We will not pay benefits for a Pre-Existing Condition that is Diagnosed within the Pre-Existing Period stated in the Schedule of Benefits.

A Pre-Existing Condition is not covered unless the loss begins after the Benefit Eligibility Period for Pre-Existing Conditions has elapsed, as stated in the Schedule of Benefits.

RIDER EXCLUSIONS

We will not pay benefits for claims resulting, whether directly or indirectly, from diseases that are related to, or are resulting from any of the following:

1. Any disease if the Covered Person was previously Diagnosed any time prior to the Rider Effective Date.
2. Any disease first Diagnosed within the Waiting Period, as shown in the Schedule, immediately following the Rider Effective Date.
3. Arrhythmia resulting in a Heart Attack that occurs in association with use of an illegal drug or controlled substance, except when administered in accordance with the advice of the Covered Person's Doctor.
4. Any amount in excess of any Maximum Benefit for Covered Conditions.
5. Diseases or conditions that do not meet the definition of a Covered Condition in this Rider.
6. Suicide or attempted suicide.

RENEWAL CONDITIONS

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

WHEN THIS RIDER ENDS

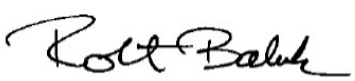
Coverage for a Covered Person under this Rider will terminate at 12:01 a.m. local time in the state of issue on the earliest of the following dates:

1. The date the Policy to which this Rider is attached is terminated;
2. The date the Covered Person asks Us, in writing, to cancel this Rider;
3. The date the Covered Person attains age 65;
4. The date the Policy lapses for non-payment of premium; or
5. The date We have paid all benefits available under this Rider.

CONDITIONS

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

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



Secretary

President

LIMITED SPECIFIED DISEASE BENEFIT RIDER
Providing Benefits for HEART ATTACK AND STROKE

SCHEDULE OF BENEFITS

RIDER EFFECTIVE DATE:	April 1, 2023
Eligible Persons:	Persons who are members of an Eligible Class as defined by the Policyholder and agreed to by Us. Eligible Classes are: All members of the Policyholder under age 60. Covered Person and Dependent Spouse coverage ends at age 65. Dependent child coverage ends at age 26 or as otherwise defined in the Certificate.
WAITING PERIOD:	60 days
MAXIMUM BENEFIT AMOUNT:	$ 5,000.00
PRE-EXISTING PERIOD:	12 Months
BENEFIT ELIGIBILITY FOR PRE-EXISTING CONDITIONS:	12 Months after the Rider Effective Date

PRE-EXISTING CONDITION: A Pre-Existing Condition is a condition for which: (a) Medical advice or treatment was recommended by, or received from a Doctor, within the Pre-Existing Period shown above; or (b) symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the Pre-Existing Period before the Effective Date of the Covered Person’s coverage. Treatment includes being prescribed or taking prescription drugs or medicines.

A Pre-Existing Condition is not covered unless the loss begins after the Benefit Eligibility for Pre-Existing Conditions has elapsed..

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

SICKNESS LUMP SUM HOSPITAL BENEFIT RIDER

In consideration of the application and payment of the required Premium, this Rider is made a part of the Policy to which it is attached. This Rider takes effect on the Effective Date shown in the Schedule of Benefits.

TEN (10) DAY RIGHT TO RETURN THIS RIDER

If the Covered Person is not satisfied with this Rider, he or she may return it to Us within ten (10) days of its receipt. It may be returned to Us by mail or to the agent who sold it. We will then refund all premiums paid for this Rider and it will be void.

RIDER DEFINITIONS

Benefit Eligibility Period for Pre-Existing Conditions means the period of time after the Effective Date of this Rider which must elapse before We will pay a benefit for a Pre-Existing Condition.

Complications of Pregnancy: Complications of Pregnancy are considered a Sickness and are conditions which:

1. When pregnancy is not terminated, require medical treatment and the diagnosis is distinct from pregnancy but is adversely affected by or is caused by pregnancy, such as:
   a. Acute nephritis;
   b. Nephrosis;
   c. Cardiac decompensation;
   d. Missed abortion;
   e. Eclampsia;
   f. Puerperal infection;
   g. R.H. Factor problems;
   h. Severe loss of blood requiring transfusion; and
   i. Other similar medical and surgical conditions of comparable severity related to pregnancy; or
2. When pregnancy is terminated by:
   a. Non-elective cesarean section;
   b. Ectopic pregnancy that is terminated; and
   c. Spontaneous termination of pregnancy during a period of gestation in which a viable birth is not possible.
3. Complications of Pregnancy will not include:
   a. False labor;
   b. Occasional spotting;
   c. Doctor-prescribed rest during the period of pregnancy;
   d. Morning Sickness;
   e. Preeclampsia; and
   f. Similar conditions associated with the management of a difficult pregnancy but which are not a separate Complication of Pregnancy.

Delivery by cesarean section is considered a Complication of Pregnancy if the cesarean section is non-elective. A cesarean section will be considered non-elective if the fetus or mother is determined to be in distress and is in immediate danger of death, Sickness or Injury if a cesarean section is not performed. A cesarean section beyond one performed in any previous pregnancy will also be considered non-elective if vaginal delivery is medically inappropriate, or a vaginal delivery is attempted but discontinued due to immediate danger of death, Sickness or Injury to the child or mother.

Covered Sickness means an illness or disease which first manifests after the Rider Effective Date for the Covered Person. All related conditions and recurring symptoms of sickness for the same Covered Person will be considered one sickness. Complications of Pregnancy, and Mental or Nervous Disorders will be considered a covered Sickness.

Covered Sickness does not include an illness or disease resulting, whether directly or indirectly, from an Accident.

All benefits are subject to any applicable Maximum Calendar Year Benefits provided under this Rider. Benefits are subject to all the terms, definitions, provisions, limitations, and exclusions in this Rider and the Policy. We will not pay benefits for Hospital Confinement that occurs during the Waiting Period shown in the Schedule of Benefits.

Hospital Confinement/Confined means a Covered Person is confined to a Hospital for a minimum of 24 consecutive hours by reason of a Covered Sickness for which benefits are payable.

Mental or Nervous Disorder: Nervous, emotional and mental disease, illness, syndrome or dysfunction classified in the most recent edition of the International Classification of Diseases as a Mental Disorder on the date the medical care or treatment is rendered to a Covered Person.

Pre-Existing Condition: A Pre-Existing Condition is a condition for which:

1. Medical advice or treatment was recommended by, or received from a Doctor, within the Pre-Existing Period shown in the Schedule of Benefits; or
2. Symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the Pre-Existing Period before the Effective Date of the Covered Person's coverage. Treatment includes being prescribed or taking prescription drugs or medicines. The Pre-Existing Period is shown in the Schedule of Benefits.

Sickness Lump Sum Hospital Benefit Amount means the amount We will pay in a Calendar Year when the Covered Person is Hospital Confined for at least 24 hours. The Sickness Lump Sum Hospital Benefit Amount is shown in the Schedule of Benefits.

Waiting Period means the number of days after the Covered Person's Effective Date before we will pay a benefit for a Covered Sickness. The Waiting Period, if any, is shown in the Schedule of Benefits.

SICKNESS LUMP SUM HOSPITAL BENEFIT

We will pay the Sickness Lump Sum Hospital Benefit when a Covered Person is Hospital Confined as an inpatient for a Covered Sickness. Benefits are payable only when:

1. A Covered Sickness is incurred by a Covered Person while his or her coverage under the Policy and this Rider is in force;
2. The Waiting Period, if any, has been satisfied; and
3. Is not otherwise excluded from coverage under this Policy and Rider.

Unless specified otherwise, benefits and their limits are per Calendar Year, per Covered Person.

The Lump Sum Sickness Hospital Benefit Amount and Maximum Benefit per Calendar Year are shown in the Schedule of Benefits.

PRE-EXISTING CONDITION LIMITATION

We will not pay benefits for a Pre-Existing Condition that is diagnosed within the Pre-Existing Period stated in the Schedule of Benefits.

A Pre-Existing Condition is not eligible for benefits unless a Hospital Confinement occurs:

1. After this Rider Effective Date;
2. After the Waiting Period, if any; and
3. After the Benefit Eligibility Period for Pre-Existing Conditions has elapsed.

RIDER EXCLUSIONS

The following Rider Exclusions are in addition to any exclusions contained in the Policy to which this Rider is attached.

We won't pay benefits under this Rider for:

1. Hospital Confinement resulting from, whether directly or indirectly, an Accident or Injury;
2. Hospital Confinement during the Waiting Period;
3. Cosmetic surgery other than:
   a) Reconstructive surgery incidental to or following surgery resulting from infection, or other diseases of the involved part; or
   b) Reconstructive surgery because of a congenital disease or anomaly.

4. Sickness arising out of or in the course of employment or which is compensable under any Workers' Compensation or Occupational Disease Act or Law;
5. Hospital Confinement for substance abuse;
6. Hospital Confinement for custodial care or confinement in an extended care or skilled nursing facility;
7. Hospital Confinement related to infertility, maternity or pregnancy, except for Complications of Pregnancy;
8. Routine well newborn care at birth including nursery care;
9. Hospital Confinement ordered or directed by a Doctor who is a Covered Person, a Family Member, an employer of a Covered Person or a person who ordinarily resides with a Covered Person;
10. Participation in the military service of any country or international organization, including non-military units supporting such forces;
11. Hospital Confinement resulting from voluntary use of alcohol or any controlled substance, as defined by statute, except when administered in accordance with the advice of the Covered Person's Doctor;
12. Any benefit in excess of the Maximum Calendar Year Benefits shown in the Schedule of Benefits;
13. Hospital Confinement outside of the United States, its possessions or Canada resulting from a Covered Sickness occurring while on a trip lasting 60 days or longer; or
14. Hospitalization resulting from suicide or attempted suicide while sane or insane.

RENEWAL

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

TERMINATION

This Rider will terminate on the earliest of:

1. The date the Policy to which this Rider is attached is terminated;
2. The date the Covered Person asks Us, in writing, to cancel this Rider;
3. The date the Covered Person attains age 65;
4. The date the Policy lapses for non-payment of premium;

PREMIUM

This Rider requires the payment of premium in addition to the premium due for the Policy.

We can change the premium for this Rider if We change it for all riders like this one in the Covered Person's state on a class basis. Before any change in premium becomes effective, We will provide the Covered Person with advance written notice in the time stated in the Policy.

CONDITIONS

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

Signed for Guarantee Trust Life Insurance Company in Glenview, Illinois, by:

Secretary

President

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

SICKNESS LUMP SUM HOSPITAL BENEFIT RIDER
SCHEDULE OF BENEFITS

Rider Effective Date:	
Eligible Persons:	Persons who are members of an Eligible Class as defined by the Policyholder and agreed to by Us. Eligible Classes are: All members of the Policyholder under age 60. Covered Person and Dependent Spouse coverage ends at age 65. Dependent child coverage ends at age 26 or as otherwise defined in the Certificate.

Lump Sum Hospital Benefit Amount:	$2,500 per Hospital Confinement

Lump Sum Hospital Benefit Amount:
10% of Hospital Benefit Amount for First Day of Hospital Confinement within a Calendar Year
30% of Hospital Benefit Amount for Second Day of Hospital Confinement within a Calendar Year
30% of Hospital Benefit of Hospital Benefit Amount for a Third Day of Hospital Confinement within a Calendar Year
30% of Hospital Benefit of Hospital Benefit Amount for a Fourth Day of Hospital Confinement within a Calendar Year

Lump Sum Hospital Benefit Waiting Period:	30 Days
Maximum Calendar Year Benefit:	One Hospital Confinement

Pre-Existing Period:	12 Months
Benefit Eligibility Period for Pre-Existing Conditions:	12 Months after the Rider Effective Date

PRE-EXISTING CONDITION: A Pre-Existing Condition is a condition for which: (a) Medical advice or treatment was recommended by, or received from a Doctor, within the Pre-Existing Period shown above; or (b) symptoms existed which would cause an ordinarily prudent person to seek diagnosis, care or treatment within the Pre-Existing Period before the Effective Date of the Covered Person's coverage. Treatment includes being prescribed or taking prescription drugs or medicines.

A Pre-Existing Condition is not covered unless the loss begins after the Benefit Eligibility Period for Pre-Existing Conditions has elapsed.

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

Amendment to Policy/Certificate Form

Effective Date: _____

This Amendment is made a part of Policy/Certificate form series MP-1400/GC-1400. This Amendment takes effect on the Effective Date shown above. If no date is shown above, it begins on the Policy's/Certificate's Effective Date.

The provision entitled **"Payment of Claims,"** is hereby deleted and replaced with the following:

Payment of Claims: Benefits payable under the Policy for Your loss of life will be paid to Your beneficiary on record with the Company. If no beneficiary has been designated by You, benefits will be paid to Your estate. Benefits payable for losses sustained by Your Dependents are payable to You. Any other payable benefits remaining unpaid at the time of Your death may, at Our option, be paid to any relative by blood or connection by marriage or to Your estate. All other benefits will be payable to You or to a medical services provider if We have received a valid assignment of benefits signed by You.

If any benefit under the Policy is payable to a beneficiary who is a minor or otherwise not competent to give a valid release, the Company may pay such benefit, up to an amount not exceeding $1,000, to such minor's parent, guardian or other person actually supporting him/her. Any payment made by the Company in good faith pursuant to this provision shall fully discharge the Company to the extent of such payment.

Subject to Your written direction in the application or otherwise, all or a portion of any indemnities provided by this Policy on account of medical, surgical, hospital, nursing, or dental services may be paid directly to the medical service provider rendering such services if a valid assignment is received by the Company before claim payment is made, unless You request otherwise in writing not later than the time of filing proofs of such loss.

Change of Beneficiary: You have the right to change the beneficiary. The consent of the beneficiary or beneficiaries shall not be requisite to any change in beneficiary.

CONDITIONS

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

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

Secretary

President

NOTICE OF PROTECTION PROVIDED
BY WYOMING LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Wyoming Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Wyoming law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company or health maintenance organization becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Wyoming law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values
- Health Insurance
  - $300,000 in health benefit plan benefits
  - $300,000 in disability insurance benefits
  - $300,000 in disability income insurance
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits
- Annuities
  - $250,000 in present value of benefits including net withdrawal and net cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer or health maintenance organization does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Wyoming law.

EXCLUSIONS FROM COVERAGE

Policy owners, contract owners, policy holders, certificate holders and enrollees are not protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer or health maintenance organization was incorporated in another state whose

guaranty association protects insureds who live outside that state);
- the insurer or health maintenance organization was not authorized to do business in this state;
- their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a stipulated premium insurance company, a local mutual burial association, a mutual assessment company, or similar plan in which the policy-holder is subject to future assessments, by an insurance exchange or by an entity similar to those listed here.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or health maintenance organization or for which the individual has assumed the risk, such as a variable contract sold by prospectus, claims based on side letters or other documents, or misrepresentations of or regarding policy benefits;
- any policy of reinsurance (unless an assumption certificate was issued pursuant to the reinsurance policy or contract);
- interest rate yields that exceed an average rate or interest earned on an equity indexed policy;
- dividends;
- experience rating credits given in connection with the administration of a policy to a group contract holder;
- annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;
- unallocated annuity contracts (which give rights to group contract holders, not individuals);
- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- an obligation that does not arise under the express written terms of the policy or contract;
- any policy providing benefits under Medicare Part C, Medicare Part D or Medicaid;
- rights to receive payments acquired through a structured settlement factoring transaction.

To learn more about the above protections, protections relating to group contracts or retirement plans, and all exclusions from coverage, please visit the Association's website at www.wylifega.org or contact:

Wyoming Life and Health Insurance Guaranty Association
6700 N. Linder Road, Suite 156, Box 139
Meridian, ID 83646
Toll Free: (800) 362-0944
Fax: (208) 968-0206
Website: www.wylifega.org
Email: administrator@wylifega.org

Wyoming Department of Insurance
106 East 6th Avenue
Cheyenne, WY 82002
Phone: (307) 777-7401
Toll Free: (800) 438-5768
Fax: (307) 777-2446
Website: doi.wyo.gov
Email: wyinsdep@wyo.gov

Insurance companies and agents are not allowed by Wyoming law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance.

When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Wyoming law, then Wyoming law will control.

GUARANTEE TRUST LIFE INSURANCE COMPANY
PRIVACY NOTICE

At Guarantee Trust Life Insurance Company (GTL) we know the importance of the right to privacy. That's why protecting the information that personally identifies each and every one of our valued insurance customers is high priority, and a matter we take very seriously.

Our primary goal is, and will continue to be, providing competitive, fairly priced, and exceptional quality insurance products to meet the short-term and long-term financial needs of our customers. From life and health insurance to credit life and credit disability insurance, getting people the protection they need is not just a job to us. It is a privilege.

While the personal, financial and medical information shared with us (from applying for coverage, to filing a claim) is the cornerstone to providing the high-quality insurance protection and service our customers have come to know and expect, be assured that information, unique to our insurance customers, is kept secure, confidential and used expressly for the purpose of conducting our insurance relationship with them. Remember, protecting our customer's privacy is not only our priority…it's a promise.

The following is a summary of our privacy policy and practices. It tells you about the kinds of personally identifiable information we collect, disclose or share with others.

INFORMATION WE COLLECT AND SOURCES OF INFORMATION

In order for GTL to provide and administer the insurance products we offer, we collect personal information about the customer. Some of the information we collect is "nonpublic". The nonpublic personal information we collect is obtained from the following sources:

- Information we receive on the application for insurance or other forms (such as name, address, telephone number, age, social security number, and beneficiary designation.)
- Information about our customer's transactions with us and our affiliates (such as the type of insurance product purchased, the premium paid, the method of purchase, and payment history.)
- Information we receive from third party reports, (such as consumer-reporting/credit agencies, motor vehicle records, and medical information. All medical information we receive is subject to the Medical Confidentiality rules described below.)

INFORMATION WE DISCLOSE

GTL does not disclose any nonpublic personal information about our customers or former customers to anyone without providing notice of the customer's rights to either opt out or opt in the sharing of personal information, except as permitted or required by law. We may also disclose all of the information we collect, as described above, with the following:

- Affiliates – We may share information with our affiliates. Our affiliates offer products and services that may complement insurance purchases and we believe may be of interest to our customers.
- Service Providers – We may share information with companies engaged to perform services on

our behalf, such as third party administrators and vendors hired to effect, administer or enforce a transaction a customer requests or authorizes; to develop or maintain computer software; or to perform market research.
- Joint Marketing – We may share information with companies that perform marketing services on our behalf or to other financial institutions with which we have a joint marketing agreement.

MEDICAL CONFIDENTIALITY

All medical information is kept confidential. We will not use or share, internally or with third-parties, our customer's medical information except for the purposes of:

- Underwriting;
- Administering the policy or claim;
- As permitted or required by law; or
- As authorized by the customer.

SECURITY AND CONFIDENTIALITY OF CUSTOMER INFORMATION

We restrict access to nonpublic personal information about our customers to those employees (or people working on our behalf under confidentiality agreements) who need to know the information in order to provide products and services. We also maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard all nonpublic personal information.

G•T•L
Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, Illinois 60025
1-800-338-7452
Visit us at: www.gtlic.com

GUARANTEE TRUST LIFE INSURANCE COMPANY

1275 Milwaukee Avenue
Glenview, Illinois 60025

CERTIFICATE OF INSURANCE

This is Your Certificate of Insurance (Certificate) while You are insured. It briefly explains the rights and benefits that are determined by the Master Policy (Policy). The Policy is a legal contract between the Policyholder and Us. The Policyholder is shown on the Schedule of Benefits.

The Policy alone constitutes the agreement under which payments are made. We will pay the benefits set forth in the Policy. Benefit payment is governed by all the terms, conditions and limitations of the Policy. The Policy may be amended at any time without Your consent or notice to You. Any such amendment will not affect a claim starting before the amendment takes effect.

The Policy has been issued and delivered to the Policyholder in the state of Texas. Except as otherwise stated in this Certificate, the Policy will be governed by the laws of the state where the Policy was issued. The Policy is held by the Policyholder. You may inspect it at any time during business hours at the office of the Policyholder.

This Certificate was issued on the basis that the information on Your enrollment form was correct and complete. If any information on the enrollment form was not correct, write to Us within ten days of receipt of this Certificate. An error or omission in Your enrollment form may result in loss of coverage as of its Effective Date.

Right to Examine: If You are not satisfied with this Certificate, return it to Our home office within twenty (20) days after the date You received it. This Certificate will then be canceled and any Premium paid will be refunded.

READ YOUR CERTIFICATE CAREFULLY.

Secretary

President

RENEWABLE TERM LIFE INSURANCE COVERAGE

NON-PARTICIPATING

LCCVXX100

TABLE OF CONTENTS

LCTCXX100

DEFINITIONS

The terms listed below, if used, have the meaning stated.
LGDFXX100

Age: Your age on Your last birthday. Your age at any Certificate Anniversary date is Your age at Your last birthday.

Beneficiary: The person named in the enrollment form or in the most recent change on record to receive the benefits payable at the Your death. We may rely on affidavits or other evidence in identifying the persons in any class named as Beneficiary. Any payment we make will be made in good faith based on this evidence and will satisfy to that extent what We owe on the Policy.

Certificate Anniversary: The same date and month as the Certificate Date for each succeeding year this Certificate remains in force.

Certificate Date: The date this Certificate begins. This is the date from which Certificate Anniversaries, Certificate Years, certificate months, and Premium due dates are determined. The Certificate Date is shown in the Schedule of Benefits.

Certificate Year: The period from the Certificate Date to the first Certificate Anniversary, or from one Certificate Anniversary to the next. A Certificate Year does not include the Certificate Anniversary at the end of the Certificate Year.

Company: Guarantee Trust Life Insurance Company, a mutual company. Also hereinafter referred to as We, Us and Our.

Covered Person: A person who has satisfied all of the following requirements:
- He is eligible for coverage under this Certificate;
- He has been accepted for coverage under this Certificate or has been automatically added;
- Premium has been paid for him; and
- His coverage has become effective and has not terminated.

LGDFXX200

Dependent: A person who resides with the Insured and is the Insured's:

- Legally married spouse.
- Child who is dependent upon the Insured for support and maintenance and is under the age of 19.

The term child refers to the Insured's unmarried:
- Natural child;
- Stepchild or foster child; A stepchild is a Dependent on the date You marry the child's parent.
- Adopted child, including a child placed with the Insured for the purpose of adoption, from the moment of placement as certified by the agency making the placement.

LGDFXX300

Owner: The person who may exercise all Certificate privileges and rights while the Insured is living. The Owner may be someone other than the Insured. The Owner is named in the Schedule of Benefits.
LGDFXX400

Policyholder: The entity shown as the Policyholder on the Schedule of Benefits.
LGDFXX500

We, Our, and Us refers to Guarantee Trust Life Insurance Company

You, Your and **Yours**: The Eligible Person as defined in the Master Policy.

Male pronouns whenever used in this Certificate include female pronouns.

LGDFXX600

ADDITIONAL DEFINITIONS

LGDFXX700

Accident: A sudden, unforeseeable, external event which results in an Injury.
LGDFXX800

Injury: Bodily injury due to an Accident which:

- Results solely, directly and independently of disease, bodily infirmity or any other causes;
- Occurs after the Covered Person's effective date of coverage;
- Occurs while coverage is in force.

All injuries sustained in any one Accident, including all related conditions and recurrent symptoms of these injuries, are considered a single injury.
LGDFXX1000

CONDITIONS OF INSURANCE

ELIGIBILITY

Insured: You are eligible for coverage if You are a member of an eligible Class and complete a valid enrollment form. Eligible Classes are shown in the Master Application.

Dependent *(See Schedule of Benefit Page for Dependent Eligibility)***:** When a Dependent is a member of an eligible Class, such Dependent is eligible for coverage on the later of:

- The date You become eligible for insurance; or
- The date You acquire the Dependent.

A Dependent is deemed to be acquired as follows:

Spouse: On the date of the marriage to You.
Natural child: On the date of birth.
Adopted child: From the moment of placement with You for the purpose of adoption, as certified by the agency making the placement.
Stepchild: On the date of Your marriage to the child's parent.
LGCIXX100

EFFECTIVE DATES OF COVERAGE

Insured
Your Effective Date of coverage is shown in the Schedule of Benefits.
LGCIXX300

Dependent, except Dependents Acquired After the Effective Date: The Effective Date of coverage for a Dependent is shown in the Schedule of Benefits. In no event will Dependent coverage become effective prior to the date Your coverage becomes effective. If a Dependent is Totally Disabled on the date on which he would become insured, his effective date will be delayed until 12:01 a.m. of the day following the date the Total Disability ends.

Total Disability/Totally Disabled means, with respect to a covered Dependent, hospital confinement. Hospital Confinement means confinement in a Hospital for at least 18 consecutive hours for which a room and board charge is made.

A person who qualifies as a Dependent on the Effective Date whom You choose not to have insured under this Certificate as of that date may become insured at a later date subject to payment of the required premium and Our approval of any satisfactory proof of good health which We may require. Coverage would take effective on the first day of the calendar month coinciding with or next following Our receipt of premium and any satisfactory proof of good health which We may require.

Dependents Acquired After the Effective Date

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

Adopted Child: Coverage for a child adopted by You is effective upon the earlier of the date of placement for the purpose of adoption or the date of the entry of an order granting You custody of the child for purposes of adoption. Coverage will continue unless the placement is disrupted prior to legal adoption and the child is removed from placement. However, You must notify Us in writing within 31 days of such adoption and pay the required additional premium, if any, in order to have coverage for the adopted child continue beyond such 31 day period.

Other Than Newborn or Adopted Child: A person who qualifies as a Dependent after the Effective Date of coverage may be insured under this Certificate. An application for insurance must be sent to Us within 31 days after the person first qualifies as a Dependent, and the required premium must be paid. Coverage takes effect as of the date the person first qualifies as a Dependent.

If the application for insurance is received more than 31 days after the person first qualifies as a Dependent, coverage will be effective on the first day of the calendar month coinciding with or next following Our receipt of premium and approval of any satisfactory proof of good health which We may require.

LGCIXX400

TERMINATION

The insurance on any Covered Person shall automatically terminate on the earliest of:

- The date the Policy terminates;
- The date the Death Benefit is paid;
- The first day of the month after the date the Covered Person ceases to be a member of a class eligible for coverage;
- The Date Certificate Ends as stated in the Schedule of Benefits;
- Any Premium due date at which time We terminate the Policy with 30 days written notice; or
- On the premium due date that falls on or next follows the date You attain the Termination Age stated in the Schedule of Benefits.

LCCIXX100

CONVERSION PRIVILEGE

Your Conversion Privilege

You may convert Your coverage to a different individual policy if:

- Your coverage terminates or is reduced, while the Policy is in force, and one of the following applies:
  a) You are no longer in a class eligible for coverage; or
  b) You change from one eligible class to another providing lower benefits.

  The amount of life insurance may not exceed the amount terminated under the Policy.

- You have been continuously insured under the Policy for at least 3 years and Your coverage terminates because the Policy terminates, or the Policy is amended so as to terminate insurance for Your class.

  The amount of insurance for this converted policy will be the amount for which You were insured under the Policy less the amount for which You become eligible under any group policy issued or reinstated by Us or another insurer within 31 days of termination.

You may not exercise this Conversion Privilege if Your coverage ends due to Your request to end Your coverage or membership in an eligible class.

To convert Your coverage You must:

Make written application to Us within 31 days after Your insurance ends; and

- Include the first premium payment with Your application. The premium will be based on the rates filed by Us for the policy to be issued. It will also be based on Your attained age and class of risk, and the amount of insurance.

When We receive Your written application and first premium payment, We will issue to You an individual life insurance policy. The issuance of the policy will be subject to the following conditions:
- No proof of insurability is needed;
- The individual policy will be on one of the forms, except term insurance, that We issue for conversion coverage; and
- The individual policy may not contain disability, accidental death and dismemberment or other supplementary benefits.

Any individual policy issued under this Conversion Privilege will be in lieu of all other benefits under this Certificate.

If You die within the 31-day conversion period, We will pay, upon receipt of proof of Your death, the amount of Your life insurance that You were entitled to convert. The claim will be paid under the Group Policy, even if the application or payment of the first premium for the individual policy has not been made.

If You have converted Your coverage to an individual policy, You will not have to surrender Your conversion policy if You become insured again under this Certificate. If You once again become ineligible for coverage under this Certificate, You will not be able to convert Your coverage a second time if Your original individual conversion policy is still in force.

We will notify You in writing of Your rights to convert Your coverage under this Certificate. If the notice is not received within 31 days after Your insurance terminates, the application period for conversion may be extended for an additional 60 days. In no event will the application period exceed 91 days following the date of Your termination.
LGCVPWY100

Dependents Conversion Privilege

Your Dependent may convert his coverage to an individual policy if:
- Your Dependent's coverage terminates or reduced, while this Certificate is in force, and one of the following applies:
  (a) You are no longer in an Eligible Class;
  (b) You are no longer in a class eligible for Dependent coverage;
  (c) You die; or
  (d) He ceases to be a Dependent, as defined.

  The amount of life insurance may not exceed the amount for which Your Dependent was insured under this Certificate.

- Your Dependent has been continuously insured under this Certificate for at least 3 years and his coverage terminates because this Certificate terminates, or this Certificate is amended so as to terminate insurance for his class.

- The amount of insurance for this insurance certificate will be the amount for which Your Dependent was insured under this Certificate. The amount will be reduced by any amount for which Your Dependent is or becomes eligible under any group life insurance policy within 31 days of termination.

To convert his Life Insurance coverage Your Dependent must:
- Make written application to Us within:
  (a) 60 days of the termination of his insurance due to Your death; or
  (b) 31 days of the termination of his insurance in all other cases.
- Include the first premium payment with his application. The premium will be based on the rates filed by Us for the policy to be issued. It will also be based on his attained age and class of risk, and the amount of insurance.

When we receive Your Dependent's written application and first premium payment, We will issue to him an individual life insurance policy. The issuance of the policy will be subject to the following conditions:
- No proof of insurability is needed;
- The individual policy will be on one of the forms, except term insurance, that We issue for conversion coverage; and
- The individual policy may not contain disability, accidental death and dismemberment or other supplementary benefits.

Any individual policy issued under this Conversion Privilege will be in lieu of all other benefits under this Certificate.

If Your Dependent dies within the 31-day conversion period, We will pay, upon receipt of proof of Your Dependent's death, the amount of life insurance that Your Dependent was entitled to convert. The claim will be paid under the Group Policy, even if the application or payment of the first premium for the individual policy has not been made.

If Your Dependent has converted his coverage to an individual policy, he will not have to surrender such policy if he becomes insured again under this Certificate. If Your Dependent once again becomes ineligible for coverage under this Certificate, he will not be able to convert his coverage a second time if his original individual conversion policy is still in force.

We will notify Your Dependent in writing of his rights to convert his coverage under this Certificate. If the notice is not received within 31 days after insurance terminates, the application period for conversion may be extended for an additional 60 days. In no event will the application period exceed 91 days following the date of his termination.
LGCVPWY200

PREMIUMS

Payment Of Premiums: Premium must be paid on or before the date they are due. We must agree upon the mode of Your payment.
LCPPXX100

Premiums: The Schedule of Benefits shows the Premium for this Certificate, if any, and any optional benefits attached on the Certificate Date. You may pay this Premium at Our Home Office or to Our authorized designee.
LCPPXX200

The First Premium is due on or before the Certificate Date. Each later Premium is due on or before the end of the period covered by the preceding Premium. The Premiums are payable until the end of the First Term Period, or until the Covered Person's death. The First Term Period is shown in the Schedule of Benefits.
LCPPXX320 (renewable term)

Renewal Privilege: This Certificate may be renewed until the earlier of the date the Group Policy ends or the end of the First Term Period and any later term period until the Date Certificate Ends. To renew, just send Us the applicable renewal Premium within 31 days after the end of the preceding term period and while coverage under the Policy is in force. The renewal Premium is shown in the Table of Renewable Term Premiums. The Date Certificate Ends is shown in the Schedule of Benefits.
LCPPXX400 (renewable term)

Grace Period: A grace period of 31 days will be allowed for each Premium payment after the first Premium payment. Coverage will stay in force during this time unless We, the Policyholder or You have given written notice of an earlier termination date. Coverage under this Certificate will terminate as of the date Premium was due if Premium has not been paid. All unpaid premium must be paid in order for coverage to continue. This includes the Premium due for the grace period. If any Covered Person dies within the Grace Period, any unpaid Premium will be deducted from the Death Benefit.

If cancellation is during the grace period, the pro rata Premium for that part of the grace period coverage was in force must be paid.

Reinstatement: If this Certificate lapses due to non payment of premiums, it may be reinstated, provided the Policy is in force and You are an Eligible Person. Reinstatement is subject to the following conditions:

- You must submit a written request and application within 5 years after the date of lapse.
- We must approve the application for reinstatement, and We may require proof of insurability acceptable to Us.
- You must pay all past due Premiums with interest compounded annually. The Certificate Reinstatement Interest Rate will not be more than the rate shown in the Schedule of Benefits.

Coverage under any reinstated Certificate will not begin until the monthly Certificate Anniversary date on or after the date We approve the application for reinstatement.
LCPPXX600

DEATH BENEFIT

We will pay a Death Benefit to the Beneficiary if a Covered Person dies while this Certificate is in force and before the Date Certificate Ends as shown in the Schedule of Benefits. Subject to the terms and provisions of this Certificate, the Death Benefit will be the amount of life insurance payable as shown on the Schedule of Benefits. It will include interest accrued from the date of death until the date of payment. The interest rate will not be less than the rate of interest payable on death proceeds left on deposit with Us.

LGDBWY110 (renewable term)

SUICIDE EXCLUSION

If a Covered Person dies as the result of suicide or any attempt at suicide, while sane or insane within two years of his Effective Date of coverage, We will be liable only for an amount equal to the Premium paid.

With respect to an increase in the amount of insurance, We will consider the two year period to begin as of the effective date of such increase.

Our return of such Premium will be in lieu of all other benefits under this Certificate which may have been payable for that Covered Person.

LGEXXX100

ACCIDENTAL DEATH BENEFIT

If, within 90 days from the date of an Accident which occurs while coverage is in force, Injury from such Accident results in a loss covered by this benefit, We will pay the benefit in the amount set opposite such loss, as shown on the Schedule of Benefits. If more than one such loss is sustained as the result of one Accident, We will pay only one amount, the largest to which the Covered Person is entitled.

This benefit is subject to all the terms, conditions and exclusions of this Certificate.

Exclusions: No benefits are payable for any loss caused by:

- Suicide or intentionally self-inflicted Injury while sane or insane.
- War or any act of war, declared or undeclared.
- Travel, or flight in or descent from any kind of aircraft unless as a fare paying passenger on a regularly scheduled flight.
- As a passenger on an official flight of the Military Airlift Command of the United States or similar air transport services of other countries.
- Infections, except infections which occur simultaneously with or through a cut or wound sustained as the direct result of an Injury, independent of any other cause; and
- The non-accidental ingestion of a contaminated substance.
- Being under the influence of alcohol or any drug unless administered and taken as prescribed by a Doctor.
- Participation in an attempt to commit an assault or felony, or participation in a riot.
- Voluntary gas inhalation or poison voluntarily taken, administered or inhaled.
- Riding or driving as a professional in any kind of race for prize money or profit.

LGADDXX100

OWNER AND BENEFICIARY

Owner
You are the original Owner of this Certificate unless someone else is shown as Owner in the enrollment form. Ownership may be changed in accordance with the provisions captioned "Change in Owner or Beneficiary." During Your lifetime, the Owner may exercise every right this Certificate gives or We allow. If the Owner dies during Your lifetime, You will become the Owner. All changes are subject to the rights of any assignee of record, and to any endorsement on this Certificate limiting such rights.

Beneficiary
The Beneficiary is as named in the application unless changed as provided for in this Certificate. If the Beneficiary dies before You, the interest of that Beneficiary will pass to You, unless contingent Beneficiary(ies) have been named and survive. If no Beneficiary(ies) survive You, all interest of the Beneficiary(ies) will pass to You. We may rely on affidavits or other evidence in identifying the persons in any class named as Beneficiary. Any payment We make in good faith based on an affidavit or other evidence shall satisfy to that extent what We owe on this Certificate.

Change in Owner or Beneficiary: Unless this Certificate provides otherwise, while You are living, You or the Beneficiary(ies), or both, may be changed by filing with Us a signed written request for such change. If the designation to be changed is irrevocable, You must also provide the written consent of the current Beneficiary. The change will not take effect until recorded by Us at Our Home Office. Once recorded, the change will be effective as of the date the request was signed and will have no effect on any payment made by Us before recording it.

LCCPXX100

PAYMENT OF CLAIMS

To Whom Benefits Are Payable:
Dependent Death Benefits will be paid in a lump sum to You. If You should die before receiving the insurance proceeds, We will pay them to Your estate.

If a Beneficiary dies simultaneously with You, or within 10 days of Your death, Benefits will be paid as if You survived Your Beneficiary.

If You name more than one Beneficiary and do not specify the amounts, percentage shares, or order of payment of the Beneficiaries, any proceeds that become payable under this Certificate will be divided equally among all Beneficiaries. The share of any Beneficiary who has died before You will go equally to the surviving Beneficiaries, unless Your Beneficiary designation states otherwise.

If a Beneficiary is a minor or is not legally competent, We may, at Our option, pay up to $2,000 to the person or entity that has in Our opinion assumed custody and main support of such person. We will do this until the Beneficiary's legal guardian makes a formal claim.

At Our option, We may pay a part of the Death Benefit to any person who has incurred funeral or other expenses on Your behalf incident to Your last sickness and death. The maximum amount of such payment is limited to the lesser of $1,000 or the maximum amount allowed by law.

Any payment made by Us in good faith, will fully discharge Our liability to the extent of such payment.
LGCPXX100

No Valid Beneficiary Designation In Effect At The Time Of Your Death: Your death proceeds will be paid to Your estate if:

- You die without naming a Beneficiary; or
- All of Your Beneficiaries have died before You.

If payment would otherwise be payable to Your estate due to the above, We have the right to pay all or a part of the benefit to the first of the following classes of surviving relatives: Your spouse; Your children; Your parents; or Your siblings.

Any payment made by Us in good faith, will fully discharge Our liability to the extent of such payment.
LGCPXX200

SINGLE LUMP SUM PAYMENT.

Single Lump Sum Payment: We will pay the Death Benefit in a single lump sum payment, unless otherwise agreed. We will pay the benefits at Our Home Office. This Certificate must be turned in to Us when We pay the benefit.

Interest on Single Lump Sum Payment: We will add interest to Our single lump sum payment. We will compute the interest from the date of the Covered Person's death until the date of Our payment. The interest rate will be as required by law.
LGCPXX300

GENERAL PROVISIONS

Entire Contract; Changes: The Policy, including this Certificate, endorsements and the attached papers, if any, constitutes the entire contract of insurance. No change in the Policy shall be valid until approved by an executive officer of the Company and unless such approval is noted on or attached to the Policy. No agent has authority to change the Policy or waive any of its provisions.

Failure by Us to enforce any Policy provision shall not waive, modify or render such provision unenforceable at any other time; at any given time; or under any given set of circumstances, whether the circumstances are or are not the same.

Incontestability: All statements made in an enrollment form by You are representations and not warranties. No statement shall be used to contest this Certificate, the validity of coverage or reduce benefits, unless it is in writing, signed by You, and a copy of such statement is furnished to You.

After a Covered Person's coverage has been in force for 2 years under this Certificate, no statement of that Covered Person shall be used to void his insurance or to deny or reduce a claim for loss incurred after the 2 year period, except non-payment of premium.

Any reinstatement for which We require an application showing insurability will be incontestable after this Certificate has been in force during the Insured's lifetime for 2 years from the effective date of the reinstatement. Any contest of a reinstatement will be based on statements made in the application for the reinstatement.

Proof of Death: Any Death Benefit payable will be paid within 45 days of Our receipt of due proof of the Covered Person's death. Such proof must be sent to Our Home Office in Glenview, Illinois. Claim forms will be made available to the Beneficiary upon request.
LCGPWY100

Misstatement of Age: If the age of any Covered Person has been misstated, there shall be an equitable adjustment of Premium. If the amount of insurance for the Covered Person, in accordance with the terms of this Certificate, would be affected by the misstatement of age, the amount of insurance shall be adjusted to the amount to which the Covered Person would have been entitled at his correct age and the adjustment in Premiums shall be based on the adjusted amount of insurance. The Policyholder or You will be required to pay any additional Premium.
LCGPXX200

Assignment: You may assign Your rights under this Certificate. The assignment must be in writing and filed at Our Home Office. The assignment will not take effect until filed and acknowledged by Us. The assignment will be effective as of the date the request was filed and will have no effect on any payment made by Us before the assignment was filed.

Unless specifically provided otherwise, any such assignment will operate to revoke and remove the interest of all beneficiaries previously designated by You. It will also automatically operate to designate the assignee as Your beneficiary.

Any benefits which become payable to an assignee will be payable in a lump sum. Any claim made by an assignee will be subject to proof of the assignee's interest and the extent of the assignment.

We will assume no responsibility for the validity or sufficiency of any such assignment.
LCGPXX400

Non-Participating
This Certificate is non-participating. It does not share in the Company's profits or surplus earnings.
LCGPXX500

Physical Examination and Autopsy: We, at Our own expense, shall have the right and opportunity to examine the Covered Person as it may reasonably require while a claim is pending. We, at Our own expense, may also have the right to make an autopsy in the case of death, where it is not prohibited by law.
LCGPXX600

SCHEDULE OF BENEFITS

Policyholder:	United Business Association
Owner:	Association Member
Insured:	Association Member
Dependent Spouse:	is ☒ is not ☐ insured under this Certificate as of the Schedule Date.
Dependent Child(ren):	is (are) ☒ is (are) not ☐ insured under this Certificate as of the Schedule Date.
Certificate Number:	United Business Association Membership Number

Effective Date:	Date you become an Eligible Member
Certificate Anniversary Date:	The same date and month as the Effective Date for each succeeding year this Certificate is in force.
Term Period:	1 year; annually renewable thereafter for consecutive 1 year term periods.
Date Certificate Ends	The date you are no longer a member of the Eligible Class.
Eligible Class:	All active enrolled members of United Business Association residing in the United States who have attained age of 18 and are legal residents or citizens of the United States. Enrolled Eligible Spouse and enrolled Child(ren) of all active members if applicable (see chart below)
Waiting Period:	6 months Waiting period does not apply to the Accidental Death Benefit
Termination Age: **Dependent:**	Child – The limiting age as stated in the definition of Dependent Child.

Death Benefit and Premium:		
Waiting Period	6 months	
	Member Benefit	**Spouse Benefit**
Benefit During Waiting Period	$10,000 Accident Only	$5,000 Accident Only
Benefit After Waiting Period For Attained Age		
18-64	$10,000	$5,000
65-69	$5,000 + $5,000 Accident only	$2,500 + $2,500 Accident only
70+	$10,000 Accident Only	$5,000 Accident Only

Child Benefit (payable to Termination Age)
Benefit During Waiting Period: $2,500 Accident Only
Benefit After Waiting Period: $2,500

Total Premium: $4.40 (for all ages)

Certificate Reinstatement Interest Rate:	6% per year (Only applies when the premium is paid by the Association Member who is the Owner).

LCSOBXX100

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

RENEWABLE TERM LIFE INSURANCE COVERAGE

Non-Participating

NOTICE OF PROTECTION PROVIDED
BY WYOMING LIFE AND HEALTH INSURANCE GUARANTY ASSOCIATION

This notice provides a **brief summary** of the Wyoming Life and Health Insurance Guaranty Association ("the Association") and the protection it provides for policyholders. This safety net was created under Wyoming law, which determines who and what is covered and the amounts of coverage.

The Association was established to provide protection in the unlikely event that your life, annuity or health insurance company or health maintenance organization becomes financially unable to meet its obligations and is taken over by its Insurance Department. If this should happen, the Association will typically arrange to continue coverage and pay claims, in accordance with Wyoming law, with funding from assessments paid by other insurance companies and health maintenance organizations.

The basic protections provided by the Association are:

- Life Insurance
  - $300,000 in death benefits
  - $100,000 in cash surrender or withdrawal values

- Health Insurance
  - $300,000 in health benefit plan benefits
  - $300,000 in disability insurance benefits
  - $300,000 in disability income insurance
  - $300,000 in long-term care insurance benefits
  - $100,000 in other types of health insurance benefits

- Annuities
  - $250,000 in present value of benefits including net withdrawal and net cash values

The maximum amount of protection for each individual, regardless of the number of policies or contracts, is $500,000.

Note: Certain policies and contracts may not be covered or fully covered. For example, coverage does not extend to any portion(s) of a policy or contract that the insurer or health maintenance organization does not guarantee, such as certain investment additions to the account value of a variable life insurance policy or a variable annuity contract. There are also various residency requirements and other limitations under Wyoming law.

EXCLUSIONS FROM COVERAGE

Policy owners, contract owners, policy holders, certificate holders and enrollees are *not* protected by this Association if:

- they are eligible for protection under the laws of another state (this may occur when the insolvent insurer or health maintenance organization was incorporated in another state whose guaranty association protects insureds who live outside that state);
- the insurer or health maintenance organization was not authorized to do business in this state;
- their policy was issued by a fraternal benefit society, a mandatory state pooling plan, a stipulated premium insurance company, a local mutual burial association, a mutual assessment company, or similar plan in which the policy-holder is subject to future assessments, by an insurance exchange or by an entity similar to those listed here.

The Association also does not provide coverage for:

- any policy or portion of a policy which is not guaranteed by the insurer or health maintenance organization or for which the individual has assumed the risk, such as a variable contract sold by prospectus, claims based on side letters or other documents, or misrepresentations of or regarding policy benefits;
- any policy of reinsurance (unless an assumption certificate was issued pursuant to the reinsurance policy or contract);
- interest rate yields that exceed an average rate or interest earned on an equity indexed policy;
- dividends;
- experience rating credits given in connection with the administration of a policy to a group contract holder;
- annuity contracts issued by a nonprofit insurance company exclusively for the benefit of nonprofit educational institutions and their employees;
- unallocated annuity contracts (which give rights to group contract holders, not individuals);
- any plan or program of an employer or association that provides life, health or annuity benefits to its employees or members to the extent the plan is self-funded or uninsured;
- an obligation that does not arise under the express written terms of the policy or contract;
- any policy providing benefits under Medicare Part C, Medicare Part D or Medicaid;
- rights to receive payments acquired through a structured settlement factoring transaction.

To learn more about the above protections, protections relating to group contracts or retirement plans, and all exclusions from coverage, please visit the Association's website at www.wylifega.org or contact:

Wyoming Life and Health Insurance Guaranty Association
6700 N. Linder Road, Suite 156, Box 139
Meridian, ID 83646
Toll Free: (800) 362-0944
Fax: (208) 968-0206
Website: www.wylifega.org
Email: administrator@wylifega.org

Wyoming Department of Insurance
106 East 6th Avenue
Cheyenne, WY 82002
Phone: (307) 777-7401
Toll Free: (800) 438-5768
Fax: (307) 777-2446
Website: doi.wyo.gov
Email: wyinsdep@wyo.gov

Insurance companies and agents are not allowed by Wyoming law to use the existence of the Association or its coverage to encourage you to purchase any form of insurance.

When selecting an insurance company, you should not rely on Association coverage. If there is any inconsistency between this notice and Wyoming law, then Wyoming law will control.

GUARANTEE TRUST LIFE INSURANCE COMPANY
PRIVACY NOTICE

At Guarantee Trust Life Insurance Company (GTL) we know the importance of the right to privacy. That's why protecting the information that personally identifies each and every one of our valued insurance customers is high priority, and a matter we take very seriously.

Our primary goal is, and will continue to be, providing competitive, fairly priced, and exceptional quality insurance products to meet the short-term and long-term financial needs of our customers. From life and health insurance to credit life and credit disability insurance, getting people the protection they need is not just a job to us. It is a privilege.

While the personal, financial and medical information shared with us (from applying for coverage, to filing a claim) is the cornerstone to providing the high-quality insurance protection and service our customers have come to know and expect, be assured that information, unique to our insurance customers, is kept secure, confidential and used expressly for the purpose of conducting our insurance relationship with them. Remember, protecting our customer's privacy is not only our priority…it's a promise.

The following is a summary of our privacy policy and practices. It tells you about the kinds of personally identifiable information we collect, disclose or share with others.

INFORMATION WE COLLECT AND SOURCES OF INFORMATION

In order for GTL to provide and administer the insurance products we offer, we collect personal information about the customer. Some of the information we collect is "nonpublic". The nonpublic personal information we collect is obtained from the following sources:

- Information we receive on the application for insurance or other forms *(such as name, address, telephone number, age, social security number, and beneficiary designation.)*
- Information about our customer's transactions with us and our affiliates *(such as the type of insurance product purchased, the premium paid, the method of purchase, and payment history.)*
- Information we receive from third party reports, *(such as consumer-reporting/credit agencies, motor vehicle records, and medical information. All medical information we receive is subject to the Medical Confidentiality rules described below.)*

INFORMATION WE DISCLOSE

GTL does not disclose any nonpublic personal information about our customers or former customers to anyone without providing notice of the customer's rights to either opt out or opt in the sharing of personal information, except as permitted or required by law.

We may also disclose all of the information we collect, as described above, with the following:

- Affiliates – We may share information with our affiliates. Our affiliates offer products and services that may complement insurance purchases and we believe may be of interest to our customers.
- Service Providers **–** We may share information with companies engaged to perform services on our behalf, such as third party administrators and vendors hired to effect, administer or enforce a transaction a customer requests or authorizes; to develop or maintain computer software; or to perform market research.
- Joint Marketing – We may share information with companies that perform marketing services on our behalf or to other financial institutions with which we have a joint marketing agreement.

MEDICAL CONFIDENTIALITY

All medical information is kept confidential. We will not use or share, internally or with third-parties, our customer's medical information except for the purposes of:

- Underwriting;
- Administering the policy or claim;
- As permitted or required by law; or
- As authorized by the customer.

SECURITY AND CONFIDENTIALITY OF CUSTOMER INFORMATION

We restrict access to nonpublic personal information about our customers to those employees (or people working on our behalf under confidentiality agreements) who need to know the information in order to provide products and services. We also maintain physical, electronic, and procedural safeguards that comply with federal regulations to guard all nonpublic personal information.

G • T • L
Guarantee Trust Life Insurance Company
1275 Milwaukee Avenue
Glenview, Illinois 60025
1-800-338-7452
Visit us at: www.gtlic.com