Guarantee Trust Life Insurance Company – Glenview, IL
Temporary Health Insurance Application

ADMIN. USE ONLY
CASE # _____

1

A. **Requested Effective Date** _____ / _____ / _____
You may request a specific effective date (may be any day of the month) as long as the application and premium are received by Allied before the requested effective date. See brochure for details on effective dates.

PLAN OPTIONS: ❑ Monthly Billing ❑ Prepay Plan – Number of Months (1 to 6)_____
Deductible: ❑ $750 ❑ $1,250 ❑ $2,500
Supplemental Accident ❑ Yes ❑ No
Maximum Coverage Period: Six (6) Months – This coverage does not renew

2

APPLICANT'S NAME (FIRST NAME, MIDDLE INITIAL, LAST NAME)			SOCIAL SECURITY NUMBER
RESIDENCE ADDRESS			
CITY	STATE	ZIP	DAYTIME TELEPHONE (Include Area Code)
BILLING NAME/ADDRESS (IF DIFFERENT THAN ABOVE) PLEASE INCLUDE FULL MAILING ADDRESS AND PHONE NUMBER			
APPLICANT'S DATE OF BIRTH	AGE	GENDER	Applicant – Must be age 18 and less than 65 (unless applying for child only coverage) Spouse – Must be under age 65 Dependent Children – Must be age 18 or under

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Complete this section to Insure your spouse and/or children

	FULL NAME (First Name, Middle Initial, Last Name)	DATE OF BIRTH	AGE	GENDER		SOCIAL SECURITY NUMBER
SPOUSE						
CHILD #1						
CHILD #2						
CHILD #3						

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Please answer the following questions completely and accurately (any "YES" answer means coverage cannot be issued):

A. Are you or any Dependent to be insured currently pregnant, or if insuring dependents are you an expectant father or planning on adopting? .....❑ YES ❑ NO

B. Within the last five (5) years have you or any Dependent to be covered been hospital confined for four (4) consecutive days or longer? (If yes, coverage will be considered if you provide a signed and dated statement explaining the nature of any and all such hospitalizations). .....❑ YES ❑ NO

C. Within the last five (5) years have you or any Dependent to be covered received medication, been diagnosed as having or been treated by any medical professional for any of the following conditions: liver disorder; cancer (excluding basal cell carcinoma); heart or circulatory system disorder including heart attack, stroke or cardiomyopathy (but not including hypertension); diabetes; nervous system disorder including muscular dystrophy; immune system disorder including AIDS Related Complex (ARC), Acquired Immune Deficiency Syndrome (AIDS) or tested positive for Human Immunodeficiency Virus (HIV); or been hospitalized for mental or nervous disorder, alcoholism or drug abuse (including dependence or addiction)? Note: In WI, HIV test results do not need to be disclosed. .....❑ YES ❑ NO

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I understand or acknowledge the following: (a) To be eligible for coverage I (and my dependents, if applying) am either a United States citizen or have one year United States legal residency; (b) Any incomplete, misleading, deceptive or false information or statement, or other concealment, misstatement, misrepresentation or omission, material to and in this application, may result in rescission of the insurance contract and/or denial of insurance benefits; (c) This is not a continuation of any previous medical plan, including any prior temporary health insurance plan; (d) This insurance will not pay benefits for any Pre-Existing Condition (refer to the plan brochure and certificate of insurance for complete explanation); (e) By applying for this insurance coverage I am enrolling as a member of the settlor of Allied Group Insurance Trust; (f) if the application is declined and coverage is not issued, Guarantee Trust Life's only obligation will be to return any premium paid; and (g) I received and reviewed the plan brochure.

Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement may be found guilty of insurance fraud in a court of law.

I authorize the disclosure of all nonpublic personal information and individually identifiable protected health information for me (and my dependent(s), if requesting dependent coverage), including but not limited to employment status, other insurance coverage, diagnosis, prognosis, medical treatment or care and physical or mental conditions (including alcohol or drug dependency), by any physician, medical practitioner, hospital, other medical related facility, insurance company, employer or benefit plan having such information, to the Insurance Company or its legal representative, agent or vendor, for the purpose of approving enrollment and processing claims. I acknowledge and agree that this authorization shall be valid for two (2) years; that I may revoke it in writing at any time; that I may request a copy of this authorization; that enrollment and the processing of claims are not conditioned on my signing this authorization; that this authorization will be used as its own document, separate from the application; that a photocopy of this authorization shall be as valid as the original; and that I have authority to act as the personal representative of my dependent(s) (if requesting dependent coverage).

Applicant's Signature_____Date_____

Form #GTL-APPH2-03 Underwritten by Guarantee Trust Life Insurance Company Policy Form #G20031

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OPTIONAL AUTHORIZATION AGREEMENT FOR AUTOMATIC MONTHLY PREMIUM PAYMENTS

I authorize Allied National to charge my account as indicated below for my monthly insurance premium and fees. I understand my account will be charged once each month for the total amount shown as due on my monthly premium statement for the limited term of the policy of insurance issued to me. I understand that if a charge to my account is not honored, my insurance coverage could lapse prior to its termination date. I understand that if I wish to cancel my coverage prior to its termination date, I must inform Allied National of such cancellation prior to the end of the grace period corresponding to the date of cancellation. Please charge my monthly premium and fees against the following account.

NAME (as shown on account – please print) _____

❑ CREDIT CARD: ❑ MasterCard ❑ Visa – Account Number _____ Expiration Date_____

❑ CHECKING/NOW ACCOUNT: Please attach a voided check from the account you wish billed for your coverage.

SIGNATURE _____DATE_____

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AREA RATING FACTORS (based on first 3 digits of zip code of the residence address)

Alaska: 995-999 ... 2.00
Arizona: 850-853 ... 1.70
855-857, 859, 860, 863-865 ... 1.60
Arkansas: 716, 717,
719-723, 725 ... 1.60
718, 724, 726-729 ... 1.50
Delaware: 198 ... 1.70
197, 199 ... 1.60
Dist. Of Columbia*:
200, 202-205 ... 2.20
Georgia: 300-303 ... 1.70
306, 313-314 ... 1.60
308-309, 312 ... 1.50
304-305, 307, 310-311,
315-319, 398 ... 1.40
Illinois: 606 ... 2.20
600, 602-605 ... 1.90
601, 607-608 ... 1.70
609,614-615, 620-622 ... 1.40
610-613, 616-619, 623-629 ... 1.30
Indiana: 463-464 ... 1.70
462, 465-466 ... 1.40
460-461, 467-479 ... 1.30
Iowa: 500-503 ... 1.40
504-508, 510-516, 520-529 ... 1.20
Maryland: 210-212, 214,
215, 218 ... 1.50
206, 208, 216, 217, 219 ... 1.40
207, 209 ... 1.30
Michigan: 480-483 ... 1.60
488-489 ... 1.50
484, 485, 490-492, 497-499 ... 1.40
486, 487, 493-496 ... 1.30
Missouri:
630-631, 633, 640-641 ... 1.60
645 ... 1.50
634-639, 642, 644, 646-658 ... 1.30
Nebraska: 680-681 ... 1.30
682-693 ... 1.20
New Mexico: 870-875,
877-884 ... 1.40
North Carolina*:
270-276, 280-282 ... 1.40
277-279, 283-289 ... 1.30
Ohio: 440-441 ... 1.60
436, 444-445 ... 1.50
433-435, 437-439, 442-443,
446-447, 449, 452-453 ... 1.40
430-432, 448, 450-451,
454-458 ... 1.30
Oklahoma:
730-731, 740-741 ... 1.50
732-734, 735-739,
742-749 ... 1.40
Pennsylvania: 190-191 ... 2.00
150-152, 189, 192-194 ... 1.80
153-188, 195-196 ... 1.60
Rhode Island: ... 1.50
South Carolina: ... 1.50
Tennessee: 380-382 ... 1.60
371-374 ... 1.50
370, 377-379, 383-385 ... 1.40
376 ... 1.30
Texas: 770-772 ... 2.00
773-775 ... 1.90
750-753, 776-777 ... 1.70
760-761 ... 1.60
762-764, 797 ... 1.50
754-759, 765-769, 778-796,
798-799 ... 1.40
Utah: 840-841, 844, 846 ... 1.40
843, 845, 847 ... 1.30
Virginia*: 222-223 ... 1.90
220-221, 201 ... 1.70
224-231, 232-239, 240-246 ... 1.40
West Virginia: 253, 260 ... 1.60
251-252, 254-257 ... 1.50
247-250, 258-259, 261-268 ... 1.40
Wisconsin: 532 ... 1.60
531, 540, 543, 548 ... 1.50
535, 537-539, 541, 542,
544-547, 549 ... 1.40
530, 534 ... 1.30
Wyoming: 820-831 ... 1.40

*These states require the use of a state specific application form.

Plan is available in other states. Contact Allied for information.

RATES/AREAS EFFECTIVE 10/1/06

Rates $750 Deductible			Rates $1,250 Deductible			Rates $2,500 Deductible		
Age	**Male**	**Fem.**	**Age**	**Male**	**Fem.**	**Age**	**Male**	**Fem.**
thru age 29	$44	$53	thru age 29	$37	$44	thru age 29	$27	$32
30-34	$51	$66	30-34	$42	$55	30-34	$31	$40
35-39	$63	$80	35-39	$52	$66	35-39	$38	$49
40-44	$76	$94	40-44	$63	$78	40-44	$46	$57
45-49	$94	$107	45-49	$78	$89	45-49	$57	$65
50-54	$121	$130	50-54	$100	$108	50-54	$74	$79
55-59	$170	$157	55-59	$141	$130	55-59	$104	$96
60-64	$230	$211	60-64	$191	$175	60-64	$140	$129
Per Child $38			Per Child $32			Per Child $23		
Supplemental Accident Rate Per Person $4			Supplemental Accident Rate Per Person $4			Supplemental Accident Rate Per Person $4		

RATE LOAD FACTORS

EFFECTIVE DATE	PREPAY	MONTHLY
10/1/06 –12/31/06	1.00	1.25
1/1/07 – 3/31/07	1.05	1.31

RATE CALCULATION:

1) Determine rates based on deductible chosen and sex and age of each person. For child(ren) rate multiply number of children by the per child rate.

2) Add rates for optional Supplemental Accident coverage if applicable. Supplemental Accident rate is for each person applying (e.g. if applicant, spouse and 1 child apply, the rate is 3 times $4 for a base rate of $12).

3) Multiply the subtotal (E) of these rates by the Area Factor and the Rate Load Factor to get Premium Subtotal (F) and round to nearest dollar. The Rate Load Factor is determined by the requested effective date, And whether choosing Prepay or Monthly billing.

4) Add Monthly Fee to get Total Monthly Cost (H).

5) For Prepay ONLY – multiply H times number of months requested for Prepay total Cost (J).

NOTE- Business checks cannot be accepted. Payment must be made by credit card or personal check payable to Allied National.

Rates may also be calculated online at tempmedsales.alliednational.com

Online enrollment is available only through authorized Allied agent affiliates.

A. Applicant $_____

B. Spouse +$_____

C. Child(ren) +$_____

D. Supp.Acc.Option +$_____

E. Subtotal =$_____

Area Factor X_____

Load Factor X_____

F. Premium Subtotal (round to nearest $) =$_____

G. Monthly Fee +$ **12.00**

H. Total Monthly Cost =$_____

PREPAY PLAN ONLY

I. Number of Months X_____

J. Prepay Total Cost =$_____

AGENT INFORMATION

SOLICITING AGENTS SIGNATURE_____ DATE _____

Soliciting Agent's Name _____ Agency_____Allied Agent#_____

Address _____ City_____ State_____Zip_____

Tel ( )_____ Pay Commissions to:_____ SS# or Tax ID# _____

Fax ( ) _____ EMAIL _____

1) Is the soliciting agent a licensed agent in the applicant's state of residence?

❑ Yes – If Yes, please send copy of state license. ❑ No – If No, the agent is not authorized to solicit this coverage and the policy cannot be issued.

2) Is the soliciting agent currently appointed with Guarantee Trust Life Insurance Company:

❑ Direct with Guarantee Trust Life? Or ❑ Through ALLIED or another Administrator? WHO? _____

Appointment fees: Allied National will pay fee for agent appointment.

DISTRIBUTOR/GENERAL AGENT NAME: