

# Value Med Plan

Benefits are Paid Directly to You!

**PAYS IN ADDITION TO OTHER INSURANCE**

- **NO DEDUCTIBLE OR CO-PAYS**
- **NO PPO & NO HMO**
- **USE ANY DOCTOR OR HOSPITAL, ANY LICENSED PROVIDER**
- **GUARANTEED RENEWABLE TO AGE 65**

## SICKNESS & ACCIDENT MEDICAL BENEFITS SCHEDULE

### DOCTOR'S OFFICE CALLS

- **WE PAY \$75.00 PER DOCTOR VISIT**

### OUTPATIENT BENEFIT

- **WE PAY UP TO \$250.00 PER VISIT**

Doctor's Treatment, Medical Supplies, X-Rays, Lab & More!

### AMBULANCE BENEFIT

- **WE PAY \$200.00 PER SICKNESS OR ACCIDENT**

### HOSPITAL BENEFIT

- **SELECT \$500.00 OR \$100.00 DAILY** To 365 Days from the First Day

Underwritten By: Guarantee Trust Life Insurance Company  
In All Other States Except NY. Group Policy #GP2005  
LA Policy Form G0551-LA, ME Policy Form G0551-ME  
MT Policy Form G0551-MT, OR Policy Form G0551-OR  
SC Policy Form G0551-SC, MD Policy Form G0551-MD

OFFERED TO VBA MEMBERS EXCLUSIVELY  
**Value  
Benefits  
of  
America**  
a Not-For-Profit Association

Underwritten By: United National Life Insurance Company Of America  
In AR, ID, IL, KS, MO, NE, NV, NM, ND, OK, SD, TX  
Group Policy #UP2005, UT Policy Form U0551-UT  
AR Policy Form U0552-AR, OK Policy Form U0552-OK  
SD Policy Form U0552-SD, WV Policy Form U0552

**G·T·L**  
FORM ADH02.07

**UNL**

### Pre-Existing Condition Limitation

Pre-existing conditions are those medical conditions disclosed or not disclosed on the application which were diagnosed or for which medical advice or treatment was recommended or received from a Doctor within a 12 month period (6 months in ID & NV) immediately preceding the Effective Date of a Covered Person's Coverage.

Any loss due to a pre-existing condition is not covered unless the loss begins more than 12 months after the Effective Date of a Covered Person's coverage

### Exceptions and Limitations

**We won't pay for charges incurred:**

1. due to war or act of war whether declared or not;
2. due to intentionally self-inflicted injury;
3. due to Mental Illness or nervous disorders without demonstrable organic disease (Loss due to Parkinson's Disease or senile dementia is covered);
4. for normal pregnancy and child birth. Complications of pregnancy are covered as a Sickness;
5. for treatment of an injury that results from the Covered Person's commission of, or attempt to commit a felony, or from the Covered Person being engaged in an illegal activity;
6. for cosmetic surgery. But "cosmetic surgery" does not include reconstructive surgery that is incidental because of previous surgery due to trauma, infection, or other disease of the involved part;
7. for confinement in a Hospital located or care received outside of the territorial limits of the United States of America, its commonwealth partners, or the countries of Canada and Mexico;
8. for the Covered Person being intoxicated or under the influence of alcohol or a narcotic; unless administered on the advice of a Physician.
9. Doctor's Office Calls are limited to one call per week, except Maryland.
10. Outpatient Benefit maximum is \$1,000.00 per calendar year per covered adult or for each child.
11. Doctor's office visits are limited to 10 per calendar year for adults, 5 per calendar year for all children combined.

### Stable Premiums

Your premiums cannot be changed due to declining health. Your premiums can only be changed if we change the premiums of all like policies in your state. You will be notified before any changes are made.

## Value Med Plan Issue Age Unisex Rates\* - Rates Stay As Of Issue Age

		<b>Includes \$500 DAILY HOSPITAL CASH - FROM 1ST DAY</b>							First Child	Each Additional Child
		Issue Ages 18-39	Issue Ages 40-44	Issue Ages 45-49	Issue Ages 50-54	Issue Ages 55-59	Issue Ages 60-64	Issue Ages 65-69		
<b>OPTION ONE</b>	<b>Payment Mode</b>									
	<b>Monthly*</b>	\$43.00	\$45.40	\$47.80	\$69.00	\$78.60	\$110.00	\$49.80	\$4.80	
	<b>Semi-Annual*</b>	\$245.92	\$259.65	\$273.37	\$394.64	\$449.51	\$629.10	\$284.82	\$27.46	
	<b>Annual*</b>	\$483.15	\$510.11	\$537.07	\$775.32	\$883.12	\$1235.96	\$559.58	\$53.96	

**CLIENTS MUST CHOOSE OPTION ONE OR OPTION TWO**

		<b>Includes \$100 DAILY HOSPITAL CASH - FROM FIRST DAY</b>			
		Issue Ages 18-49	Issue Ages 50-59	Issue Ages 60-64	All Children
<b>OPTION TWO</b>	<b>Payment Mode</b>				
	<b>Monthly*</b>	\$31.00	\$49.00	\$70.00	\$45.00
	<b>Semi-Annual*</b>	\$177.29	\$280.24	\$400.34	\$257.36
	<b>Annual*</b>	\$348.31	\$550.56	\$786.52	\$505.62

**Monthly mode is only available as bank draft or list bill (5 or more)**

**\*Plus Savers VBA Membership: \$5.00 Monthly \$30.00 Semi-Annual \$60.00 Annual**

#### MARKETED BY:

PROFESSIONAL MASS MARKETING  
3400 CORAL WAY SUITE # 603  
MIAMI, FL 33145  
CALL TOLL FREE: 800-881-7664  
FAX: 305-441-6915

**Mail Completed Applications To:**  
Value Benefits of America  
15575 North 79th Place Suite 100  
Scottsdale, AZ 85260  
(800) 366-2467 ~ (800) 471-7996 (fax)

**GUARANTEE TRUST LIFE INSURANCE COMPANY**

1275 Milwaukee Avenue, Glenview, Illinois 60025

**APPLICATION FOR HOSPITAL CONFINEMENT INDEMNITY COVERAGE UNDER POLICY FORM GP2005**

**POLICYHOLDER**

Value Benefits of America

**APPLICANT INFORMATION**

Person(s) Applying for Coverage	Age	Date of Birth	Sex	Height	Weight	Occupation	Social Security Number
Applicant (A):							
Spouse (S):							
Child 1 (C):							
Child 2 (C):							
Child 3 (C):							
Child 4 (C):							

Address: \_\_\_\_\_ Phone: \_\_\_\_\_  
 Email: \_\_\_\_\_

**BENEFITS BEING APPLIED FOR**

Hospital Benefit To 365 Days	Child Rider	Doctor's Per Visit Benefit	Outpatient Benefit (Per Visit)	Ambulance Benefit
<input type="checkbox"/> \$500 Daily or <input type="checkbox"/> \$100 Daily	<input type="checkbox"/> Yes <input type="checkbox"/> No	\$75.00	\$250.00	\$200.00

**QUALIFYING MEDICAL QUESTIONS**

1. Within the past 12 months has any person to be insured been confined to a hospital, nursing home or other medical facility? .....  Yes  No  
 If "Yes", indicate which person, condition, diagnosis, dates and type of treatment: \_\_\_\_\_
2. In the past 24 months has any person to be insured been diagnosed or treated by a medical professional for a heart condition, stroke, internal cancer or malignant melanoma, chronic obstructive lung disease, insulin dependent diabetes, chronic liver or chronic kidney disease? .....  Yes  No  
 If "Yes", indicate which person, condition, diagnosis, dates and type of treatment: \_\_\_\_\_
3. Has any person to be insured tested positive for exposure to the HIV infection or been diagnosed as having ARC or AIDS? .....  Yes  No  
 If "Yes", indicate which person: \_\_\_\_\_

**OTHER HEALTH COVERAGE**

4. Please list all existing or pending coverage and indicate who is covered and if this coverage is to be replaced by this certificate. (Attach additional signed & dated sheet if more room is needed.)

Who Covered?	Replacing?	Company Name	Type of Coverage
<input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____
<input type="checkbox"/> A <input type="checkbox"/> S <input type="checkbox"/> C	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____	_____

**PREMIUM**

Insurance Coverage	\$ _____	Please make check/money order payable to: <b>Guarantee Trust Life Insurance Co.</b>
Association Dues	\$ _____	
TOTAL PAYMENT DUE	\$ _____	
Payment Mode: <input type="checkbox"/> Annual <input type="checkbox"/> Semi-Annual <input type="checkbox"/> Monthly		Billing Method: <input type="checkbox"/> Bank Draft <input type="checkbox"/> Direct Bill <input type="checkbox"/> List Bill

**APPLICANT'S STATEMENTS**

I HEREBY APPLY for coverage as indicated on this Application. I have read or had read to me the completed application. To the best of my knowledge and belief, the answers to the above questions are true and complete.

I UNDERSTAND AND AGREE that: (1) this coverage will be issued based solely and entirely upon my answers to the above questions; (2) no coverage will exist until a Certificate is issued, and will be in force only as of the Certificate effective date; (3) any misstatement of fact in this application may result in the denial of benefits or cause the Company to change or rescind my coverage; (4) any loss for a pre-existing condition will not be covered for the first 12 months my coverage is in force.

**WARNING:** Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**IMPORTANT NOTICE:** This policy is primarily governed by the laws of Missouri. As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida-approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services.

Dated at: \_\_\_\_\_ this \_\_\_\_\_ day of \_\_\_\_\_, 20\_\_\_\_\_

Signature of Applicant: \_\_\_\_\_

I certify that I have accurately recorded the information supplied by the applicant. I further certify that I am not aware of any additional information which may have a bearing on the insurability of anyone proposed for insurance on this application and any supplement to it.

Witness - Agent's Signature: \_\_\_\_\_

Agent's Name: \_\_\_\_\_ FL Lic. No.: \_\_\_\_\_

## HIPAA AUTHORIZATION

**This Authorization was prepared by for purposes of obtaining information necessary to underwrite my (our) application(s) for insurance.**

### Check Applicable Insurance Company

- Guarantee Trust Life Insurance Company**  
**125 Milwaukee Avenue, Glenview, IL 60025**
- United National Life Insurance Company of America**  
**PO Box 7901, Mount Prospect, IL 60056**

By signing this form, I (we) authorize the insurance company(ies) checked above (herein referred to as the "Company"), insurance support organizations, authorized representatives, and any reinsurers, to obtain information as to the diagnosis, treatment, or prognosis of my (our) physical condition, other coverage and any other information needed to underwrite my (our) application for insurance such as criminal or motor vehicle records. Upon presentation of this Authorization, or a photocopy of it, the Company may obtain, without restriction (except psychotherapy notes), such information or records from any doctor, health professional, hospital, clinic, Veterans Administration, insurance company or other person or organization which has such information including any information provided to any affiliate insurance company on previous applications and any information provided to our health division for underwriting or claim servicing purposes. The Company and its reinsurers may also obtain such information from the Medical Information Bureau. This Authorization includes all information about drugs, alcoholism, and mental illness. I (we) understand and agree that the Company or its representatives may conduct a phone interview or face-to-face assessment as part of the underwriting process. I (we) agree that this Authorization will be valid for 24 months from the date signed, and know that I (we) or my (our) authorized representative may have a photocopy of it. If this Authorization is for someone other than myself, that individual and my authority to act on their behalf is explained below.

I (we) understand that I (we) have the right to revoke this Authorization, in writing, at any time by sending written notification to my (our) agent or to the Company at the above address. I (we) understand that a revocation will not be effective to the extent the Company has relied on the use or disclosure of the protected health information or, so long as the Company has a legal right to contest a claim under the coverage or the coverage itself. Revocation requests should be sent in writing to my (our) agent or to the attention of the Company's Underwriting Manager.

I (we) understand once information is disclosed pursuant to this Authorization, such information will continue to be protected by the Company in accordance with federal or state law. I (we) also understand that my (our) application for insurance can be declined if I (we) choose not to sign this Authorization.

---

(Print Please) Name of Applicant

---

Signature of Applicant and Date

# GUARANTEE TRUST LIFE INSURANCE COMPANY

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

HOSPITAL CONFINEMENT INDEMNITY COVERAGE – THIS CERTIFICATE PROVIDES LIMITED BENEFITS

BENEFITS PROVIDED ARE SUPPLEMENTAL AND ARE NOT INTENDED TO COVER ALL MEDICAL EXPENSES

## OUTLINE OF COVERAGE

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

1. **Read Your Certificate Carefully**—This outline of coverage provides a very brief description of the important feature of coverage. This is not the insurance contract and only the actual policy provisions will control. The policy itself sets forth in detail the rights and obligations of both you and your insurance company. It is, therefore, important that you **READ YOUR CERTIFICATE CAREFULLY!**
2. Hospital confinement indemnity coverage is designed to provide, to persons insured, coverage in the form of a fixed daily benefit during periods of hospitalization resulting from a covered accident or sickness, subject to any limitations set forth in the policy. Coverage is not provided for any benefits other than the fixed daily indemnity for hospital confinement and any additional benefit described below.
3. **Benefits** – Your coverage under the group policy provides a daily benefit when you are confined to a hospital for a covered sickness or injury. This daily benefit will be paid from the fourth day of confinement and for each day you are confined for up to 365 days of confinement during your lifetime.

Daily Hospital Benefit ..... See Policy Schedule Page

4. **Exclusions and Limitations** – The policy will not cover loss resulting from pre-existing conditions during the first year that your policy is in force. A "pre-existing condition" is any sickness or injury diagnosed or for which medical advice and/or treatment was received from or recommended by a Physician within a twelve (12) month period prior to the effective date of your policy.

Your policy does not cover any sickness or injury which is the result of: (1) intentionally self-inflicted injury; (2) mental illness or nervous disorders without demonstrable organic disease (loss due to Parkinson's Disease, Alzheimer's Disease or senile dementia is covered); (3) normal pregnancy and childbirth; complications of pregnancy, however, will be covered as a sickness; (4) treatment of an injury that results from your commission of, or attempt to commit a felony, or from you being engaged in an illegal activity; (5) cosmetic surgery; cosmetic surgery does not include reconstructive surgery which is incidental because of previous surgery due to trauma, infection, or other disease of the involved part; (6) confinement in a Hospital located or care received outside of the territorial limits of the United States of America, its commonwealth partners, or the countries of Canada and Mexico; or (7) you being intoxicated or under the influence of alcohol or a narcotic, unless administered on the advice of a Physician.

5. **Renewability** – Your coverage is Guaranteed Renewable to Age 65. This means that you may keep your coverage under the group policy in force until age 65 by paying the renewal premiums as they are due or during the 31-day grace period. Once you reach age 65 your coverage under the policy will terminate.

We will have the right to change your renewal premium, but only if we change the table of premium rates for the group policy. If we make a change we will provide you with written notice at least thirty-one (31) days before any premium change is made.

**GUARANTEE TRUST LIFE INSURANCE COMPANY**  
Glenview, Illinois

HOSPITAL CONFINEMENT INDEMNITY OUTLINE OF COVERAGE

6. **Additional Benefits** – In addition to the above Daily Hospital Benefit, the following benefits are also provided:

ADULT Doctor's Office Visit Benefit, per visit, maximum 1 visit per week ..... \$75.00

Maximum Doctor's Office Visits per Calendar Year ..... 10

If the Optional Child Benefit Rider selected:

Child Doctor's Office Visit Benefit , per visit, maximum 1 visit per week ..... \$75.00

Maximum Doctor's Office Visits per Calendar Year  
for all Dependent Children ..... 5

Outpatient Benefit Amount ..... \$250.00

Maximum Calendar Year Outpatient Benefit ..... \$1,000.00

Ambulance Benefit ..... \$200.00

REMEMBER, if you are not satisfied with your coverage, you have 10 days  
to return your certificate to us and get your money back.

FOR ADDITIONAL INFORMATION ABOUT BENEFITS OR CLAIMS, TELEPHONE US AT (847) 699-0600

**[If delivered at time of application by an agent:**

Agent's Signature \_\_\_\_\_ Date of Delivery \_\_\_\_\_

Agent's Name (Printed) \_\_\_\_\_

Agent's Address and Phone No. \_\_\_\_\_ ]

# Required with all new Value Health, Value Hospital & Value Med Applications

## (1) BANK DRAFT AUTHORIZATION AGREEMENT FOR AUTOMATIC MONTHLY PAYMENTS

I hereby authorize the indicated payee(s) below to charge my account the insurance premiums and fees due monthly.

- GEM ADMINISTRATORS (VALUE HEALTH or VALUE HOSPITAL PLANS)
- UNITED NATIONAL LIFE INSURANCE COMPANY OF AMERICA (UNL)  
(VALUE MED PLAN in AR, ID, IL, MO, NE, NV, NM, ND, OK, SD, TX, UT & WV)
- GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL)  
(VALUE MED PLAN in approved states not listed above)

I understand my account will be charged once each month for the total amount shown as due for my monthly premium and fees for the 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. I further agree that you will not be under any liability for any dishonored electronic withdraws from my account, for any reason, even though the dishonor results in the forfeiture of benefits or membership. If any ACH item is dishonored, I authorize any additional returned check fees resulting from said dishonored check, to be charged to my bank account. I understand that if I wish to cancel my coverage, I must inform the named insurance company above or GEM Administrators of such cancellation within 30 days of the withdrawal date. Please charge my monthly premium and fees against the following account.

Name of Depositor, as it appears on the Bank Institutions Records \_\_\_\_\_

Account Number \_\_\_\_\_ Routing / Transit Number \_\_\_\_\_

Name of Banking Institution \_\_\_\_\_ Branch \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Please attach a voided check from the account you wish billed for your coverage.

**X** \_\_\_\_\_ Date Signed: \_\_\_\_\_

MAKE THE CHECK (S) PAYABLE TO THE AUTHORIZED PAYEE INDICATED ABOVE.

## (3) PAYMENT CALCULATION

A) INDICATE PAYMENT METHOD:  Monthly Bank Draft  Monthly List Bill \*  Semi-Annual\*\*\*\*  Annual \*\*\*\*

B) ENTER AMOUNTS:	Value Health Plan **	Value Hospital Plan **	Value Med Plan **
1. Applicant	\$	\$	\$
2. Spouse	\$	\$	\$
3. Child (Rates are per child for the Value Health /Hospital) # ____ X \$ ____ =	\$	\$	\$
4. VBA Monthly Fees: (VBA Classic Membership is required if not a current VBA member) ***	\$5.00	\$5.00	\$5.00
5. Monthly Administration Fee:	\$15.00	\$7.50	NA
6. Total Monthly Due: ****	\$	\$	\$
C) IMPORTANT PAYMENT INSTRUCTIONS:	Make check payable to GEM Administrators.	Make check payable to GEM Administrators.	Make check payable to GTL or UNL.

\* Minimum for Monthly List Bill is 2 on Value Health or Value Hospital or 5 on Value Med.  
 \*\* You can purchase only one AIG product, either the Value Health or the Value Hospital. You can purchase the Value Med alone or with either the Value Health or Value Hospital.  
 \*\*\* If you have purchased another level of VBA Membership, the \$5.00 monthly dues are waived. I have purchased another level of VBA Membership.  Yes  No  
 \*\*\*\* For Semi Annual or Annual payment modes, see below:  
 VALUE HEALTH or VALUE HOSPITAL: Semi-Annual - Multiply total by 6. Annual - Multiply total by 12.  
 VALUE MED PLAN: Semi-Annual - See brochure for rates (Add \$30 VBA dues if not already a member.)  
 Annual - See brochure for rates. (Add \$60 VBA dues if not already a member.)

## (2) VALUE BENEFITS OF AMERICA CLASSIC MEMBERSHIP ENROLLMENT FORM\*

Print Primary Member Name: \_\_\_\_\_

I agree to the Value Benefits of America terms and conditions as listed on this form.

**X** \_\_\_\_\_ Date Signed \_\_\_\_\_  
 Signature of Primary Member

### About Value Benefits of America Classic Membership:

Classic Benefits include over 400 major chains on-line in over 50 shopping categories, including everything from major department stores to specialty retailers to boutiques. In addition to earning rewards up to 25% shopping at participating on-line merchants, you can also receive point of sale discounts up to 50% from leading national retailers. Point of sale discounts are available on brand name merchandise, travel services and entertainment, including savings on movie tickets, movie rentals and at theme parks nationwide. You'll also enjoy savings of up to 60% dining at fine restaurants nationwide with discounted dining certificates, and the savings don't stop there. Included at no charge are discounts at over 55,000 pharmacies for your prescription drugs as well as lab tests and x-ray imaging services. Complete details of membership benefits are provided at [www.VBAMembers.com](http://www.VBAMembers.com).

\*Classic Membership does not include Accident Medical, Emergency Air Ambulance or Accidental Death & Dismemberment Benefits.

### VBA Terms and Conditions:

- Member understands that VBA is not an insurance company or program. Accident Benefit Payments are made by the administrator for the insurance company issuing the blanket coverage to Members.
- VBA provides savings to its members on services through a number of sources. The current list of benefits may be modified through additions or deletions. A quarterly newsletter, posted on our website or sent via e-mail, will keep Members up to date on benefits and other pertinent information.
- Payments for the VBA Program are due in advance. Payments will be drafted on or about 15 days before the due date. If you choose to cancel your program, it is your responsibility to make sure that your membership card and a written request for cancellation are sent to VBA at least 15 days prior to the anniversary of your effective date in order for your account not to be charged for additional fees.
- Member hereby appoints, Value Benefits of America Association (VBA) President, or failing this person, a VBA Director, as proxy holder for and on behalf of the member with the power of substitution to attend, act and vote for and on behalf of the member in respect of all matters that may properly come before the meeting of the members of VBA and at every adjournment thereof, to the same extent and with the same powers as if the undersigned member were present at the said meeting, or any adjournment thereof. Annual meetings are to be held in Arizona the second Tuesday of August.
- VBA reserves the right to terminate any enrollment or deny eligibility in the program for lack of payment to VBA. Returned checks, insufficient notices on bank drafts or denial by the member's credit card company for payment of the membership fee is deemed to be evidence of non-payment by a member. There will be a \$10.00 charge to be reinstated in the program after such denial. If reinstatement for non-payment happens more than once, a \$20.00 reinstatement will apply.
- In the event of any dispute, member agrees to resolve said dispute solely by binding arbitration that shall be governed by the laws of the state of Arizona and enforceable at Scottsdale, Maricopa County.
- Membership cancelled within the first 30 days of the enrollment date may be eligible for refund if the membership card and written cancellation request are sent to VBA. The administrative fee is not refundable. Approved refunds will be processed approximately 30 days after cancellation.
- Membership is effective on the 1st of the month following enrollment acceptance by VBA.

**Member Agreement:** By signing the enrollment form, Member expresses desire to become a member of Value Benefits of America. Member acknowledges that the discount plans ARE NOT INSURANCE, but membership may include certain limited supplemental insured coverage's. Membership benefits are not a replacement for health insurance coverage nor are they intended as a substitute for health insurance coverage. Membership fees may be changed for all members, but not individually, with notification.

Please Mail completed forms and your check(s) to:

**VALUE BENEFITS OF AMERICA**  
 15575 N. 79TH PLACE, SUITE 100  
 SCOTTSDALE, AZ 85260

Marketed By:

GAC #:

# GUARANTEE TRUST LIFE INSURANCE COMPANY

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

## NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

According to your application, you intend to lapse or otherwise terminate existing accident and sickness insurance policy number \_\_\_\_\_ you have with \_\_\_\_\_ Insurance Company and replace it with a policy to be issued by Guarantee Trust Life Insurance Company. Your new policy provides 10 days after receipt of the policy within which time you may decide whether you desire to keep the policy. For your information and protection, you should be aware of and seriously consider certain factors that may affect the insurance protection available to you under the new policy.

- (1) Health conditions which you may presently have (pre-existing conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
- (2) Even though some of your present health conditions may be covered under the new policy, these conditions may be subject to certain waiting periods under the new policy before coverage is effective.
- (3) You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
- (4) If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain that all questions on the application concerning your medical/health history (if any) are truthfully and completely answered. Failure to include all material medical information on an application may provide a basis for the company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed it should be carefully reviewed before being signed to be certain that all information has been properly recorded.
- (5) New Policies may be issued at an older age than that used for issuance of your present policy; therefore, the cost of the new policy, depending upon the benefits, may be higher than you are paying for your present policy.
- (6) The renewal provisions of the new policy should be reviewed so as to make sure of your rights to periodically renew your policy.

The above "Notice to Applicant" was delivered to me on:

\_\_\_\_\_  
(Date of Delivery)

Witness: \_\_\_\_\_  
(Licensed Resident Agent)

\_\_\_\_\_  
(Applicant's Signature)



# VALUE MED PLAN AGENT GUIDELINES

United National Life Insurance Company of America (In AR, ID, IL, MO, NE, NV, NM, ND, OK, SD, TX, UT & WV)  
 Underwritten by Guarantee Trust Life Insurance Company (In all other approved states)

1. **ISSUE DATE:** Business is issued on the date approved in underwriting by the carrier (usually in 10 days). You can request a later effective date with a note attached to the application. If no money is received the carrier may need up to 15 days.
2. **MONIES COLLECTED:** Make checks payable to the insurance company. Applicants can pay by Monthly Bank Draft, Semi-Annual, Annual or Monthly List Bill. Make sure the applicant is aware that their account will be drafted immediately if they did not submit money and thereafter (after issuance) approximately 15 days prior to the due date. The insurance company processes the monthly collections for individuals on the Value Med. (List bill instruction are in #6 below).
3. **ORIGINAL APPLICATION(S) ARE PREFERRED:** We do accept legible fax/photo copies. If not legible, issue is delayed for the original.
4. **MUST INCLUDE THESE SIGNED FORMS:** HIPAA Authorization, VBA membership enrollment and an Automatic Monthly Bank Draft (and voided check).
5. **CONTACT INFORMATION:** Most correspondence regarding application is sent to the agent via email, phone or mail. We may be required to call on the customer, so always include the email address, if available and the phone number.
6. **LIST BILL:** No group participation and a minimum of 5 or more employees must apply. The 1st month's premium and fees must be paid to issue on a List Bill. Please use the GEM Administrators List Bill Form. If sold along with the Value Health/Hospital Plans the check should be payable to GEM Administrators. If only the Value Med is sold, the check should be payable to either GTL / UNL.
7. **COMMISSION PAYMENT:** New business will be paid weekly upon issue and renewals on or about the 20th of each month.
8. **CHANGES AND CANCELLATIONS:** Any changes, including cancellations must be in writing and sent to GAC or the insurance carrier.
9. **FULFILLMENT:** All fulfillment information, Certificate of Insurance and ID cards will be mailed directly to your client.
10. **CHILD COVERAGE:** If age 18, they need to apply separately on their own application.  
*We are waiting for state approval on a rider the insurance company filed, allowing child coverage to be added.*
11. **COVERAGE REPLACEMENT:** GTL/UNL requires a signed **Replacement Form** in the states of: AR, CO, DE, FL, IA, ID, IL, KY, MA, NH, OK, PA, SC, TX, UT, VA, VT, WI & WV. Also list the reason coverage is being replaced.
12. **OUTLINE OF COVERAGE:** Some states have an outline of coverage form: AR, ID, ME, MT, NH, OK, OR, SC, UT, VT & WV

## UNDERWRITING GUIDELINES

The applicant and spouse height and weight must be within the guidelines listed on the chart.

### APPLICATION QUESTION 1:

If "Yes" answer provide details. If the hospitalization or other confinement was due to a fracture or minor surgery (gall bladder, appendix or child birth) the applicant can qualify. If for a major surgery, or hospitalizations or other confinements due to a major illness or sickness, the applicant will not be eligible for the plan.

### APPLICATION QUESTIONS 2 & 3:

If "Yes" is answered for either question, the applicant will not be eligible for the coverage.

### THERE ARE NO RATE UPS AND NO ELIMINATIONS!

*Underwriting decisions are made based on the information disclosed on the application for insurance. Any false or incomplete information listed on the application can result in a rescission within the first 2 years of coverage.*

### PRE-EXISTING CONDITION LIMITATION:

Pre-existing conditions are those medical conditions disclosed or not disclosed on the application which were diagnosed or for which medical advice or treatment was recommended or received from a Doctor within a 12 month period (6 months in ID) immediately preceding the Effective Date of a Covered Person's coverage. Any loss due to a pre-existing condition is not covered unless the loss begins more than 12 months after the Effective Date of a Covered Person's coverage.

FEMALE			MALE		
Height	Min Weight	Max Weight	Height	Min Weight	Max Weight
4'8"	77	212	5'0"	91	234
4'9"	78	216	5'1"	93	237
4'10"	79	220	5'2"	95	243
4'11"	81	224	5'3"	98	247
5'0"	83	229	5'4"	101	256
5'1"	85	238	5'5"	103	262
5'2"	87	243	5'6"	106	270
5'3"	89	244	5'7"	109	276
5'4"	91	250	5'8"	112	286
5'5"	93	256	5'9"	115	296
5'6"	96	262	5'10"	118	299
5'7"	98	268	5'11"	121	308
5'8"	101	274	6'0"	124	312
5'9"	104	287	6'1"	127	323
5'10"	107	288	6'2"	131	328
5'11"	110	296	6'3"	134	339
6'0"	114	305	6'4"	138	360
6'1"	117	314	6'5"	142	385
6'2"	120	323	6'6"	146	409
			6'7"	150	418
			6'8"	154	427

Questions or Supplies: Call GAC National Marketing Division

1-800-981-VALU (8258) ■ Fax: 1-775-256-3023

Email: [jomarie@GeneralAgentCenter.com](mailto:jomarie@GeneralAgentCenter.com)

or [jomarie123@aol.com](mailto:jomarie123@aol.com)

Address: 23839 Coral Ridge Lane, Land O'Lakes, FL 34639

VBA/VM.UW 1/07