

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.

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; or
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.

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.

Issue Age Unisex Rates* Rates Stay As Of Issue Age

Issue Ages	Monthly	Semi-Annual	Annual
18-49	\$31.00	\$177.29	\$348.31
50-59	\$49.00	\$280.24	\$550.56
60-64	\$70.00	\$400.34	\$786.52

*Plus Savers VBA Membership: \$5.00 \$30.00 \$60.00

Mail Applications To:
Value Benefits of America
15575 N 79th Pl - #100
Scottsdale, AZ 85260
(800) 366-2467

Administrator:
GEM Administrators
919 N 1st St
Phoenix, AZ 85004
(800) 756-4906

This brochure is a brief summary of benefits only and is subject to the terms, conditions, exclusions and limitations of your Policy.
Coverage may vary or may not be available in all states.

GUARANTEED 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, Inc.

APPLICANT INFORMATION

Person(s) Applying for Coverage	Age	Date of Birth	Sex	Height	Weight	Occupation	Social Security Number
Applicant (A):							
Spouse (S):							

Address: _____ Phone: _____
 Email: _____

BENEFITS BEING APPLIED FOR

Daily Hospital Benefit	Doctor's Per Visit Benefit	Outpatient Benefit (Per Visit)	Ambulance Benefit
\$200.00 (after 3 days)	\$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 been medically diagnosed as, or is any person to be insured receiving or been advised by a doctor to seek treatment for being HIV-positive or having AIDS or AIDS-related complex? Yes No

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 needed.)

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

PREMIUM

Insurance Coverage \$ _____
 Association Dues \$ _____
 TOTAL PAYMENT DUE \$ _____

Please make check/money order payable to:

GEM Administrators

Payment Mode: Annual Semi-Annual Monthly

Billing Method: Direct Bill Bank Draft 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 defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and may subject such person to criminal and civil penalties.

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: _____ Agent's Number(s): _____

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 the reverse side of this form.

Signature of Primary Member: **X** _____ Date Signed: _____

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

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.

Payment Calculations For Members

(Please insert N/A on dollar line when not purchasing that plan.)

	<input type="checkbox"/>	Monthly Bank Draft	<input type="checkbox"/>	Semi- Annual**	<input type="checkbox"/>	Annual**	<input type="checkbox"/>	Monthly List Bill
VBA Classic Membership Level (Required) -----	<input checked="" type="checkbox"/>	\$ 5.00*	<input type="checkbox"/>	\$ 30.00*	<input type="checkbox"/>	\$ 60.00*	<input type="checkbox"/>	\$ 5.00*
<u>VALUE HEALTH PLAN</u> -----	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	\$ _____
Value Health Plan Only \$15.00 Monthly Admin Fee	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	\$ _____
<u>VALUE MED PLAN</u> -----	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	\$ _____
TOTAL FOR ALL ABOVE -----	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	\$ _____	<input type="checkbox"/>	\$ _____

***(Semi-Annual = Monthly X 6, Annual = Monthly X12)*
(List Bill Groups - Minimum of 2 with Value Health Plan. 5 or More otherwise)

***If you have purchased another level of VBA Membership, the \$5.00 dues are waived.**
I have purchased another level of VBA Membership Yes No

Make check payable to:
GEM Administrators

Send all forms and checks to:
Value Benefits of America
15575 N 79th PI - #100
Scottsdale, AZ 85260

Bank Draft Authorization Form

GEM ADMINISTRATORS AUTHORIZATION TO HONOR CHECKS, SHARE DRAFTS, OR ACCOUNT DEBITS

Name of Depositor as it appears on Banking Institution Records _____

Account Number	Routing/Transit Number	Name of Banking Institution	Branch
Address		City	State Zip

As a convenience to me, I authorize you to pay and charge to my account checks, share drafts, electronic fund transfer debits or other account debits made upon my account by and payable to the order of the entity designated above or its legal representatives for membership, benefits and/or premiums. I agree that your treatment of each check, share draft or debit, and your rights with respect to it, will be the same as if it were signed or initiated personally by me. I further agree that if any check, share draft or debit is dishonored for any reason you will not be under any liability even though dishonor results in the forfeiture of benefits or membership. If any ACH item is dishonored, I authorize an additional returned check fee of the state allowable amount to be charged to my bank account. I further agree that this authorization is to remain in effect until you receive written notice from me of its revocation unless you end it earlier.

X _____ Date Signed: _____

VBA Terms and Conditions

1. 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.
2. 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.
3. 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.
4. 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.
5. 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.
6. 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.
7. 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.
8. Membership is effective on the 1st of the month following enrollment acceptance by VBA.

Member Agreement:

By signing the enrollment form on the reverse side, 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 coverages. 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.

ENDORSEMENT

Thank you for considering Value Benefits of America, Inc. (VBA), a not for profit association, and the companies providing insurance coverage to its members in planning for your financial security. We appreciate the opportunity you have given us to present our products to you.

In order for you to make an informed decision regarding application for coverage(s), we have developed a detailed brochure(s) that outline(s) the provisions of the insurance plan(s). Please read the brochure(s) carefully and call our Alabama Customer Service Unit if you have any questions regarding information contained in the brochure(s).

VBA and the issuing insurance carriers will rely on answers given on your application(s) for coverage(s) in order to determine if coverage(s) can be issued. Moreover, we have the right to rescind coverage(s) or deny claims based on the failure to provide accurate information at the time of application. If you are applying for any coverage(s) that is(are) subject to insurability it may result in additional investigations while the application(s) is(are) being underwritten and at time of any claim. Any underwriting decision will rely upon the cooperation of medical providers and proactive assistance from you, the applicant, in obtaining medical information needed to determine eligibility for coverage(s).

Please remember some coverage(s) for which you are applying may have wording that may limit benefits for a pre-existing medical condition for which you had treatment, took medication, received a diagnosis, or incurred expense. It may also have wording that could limit or reduce your benefits.

PLEASE ACKNOWLEDGE THAT YOU HAVE RECEIVED A COPY OF THE BROCHURE(S) _____

BY SIGNING THIS FORM. A COPY OF THIS FORM WILL BE ENCLOSED WITH YOUR CERTIFICATE AND/OR POLICY.

ARBITRATION AGREEMENT

IN THE EVENT OF ANY DISPUTE, CLAIM QUESTION, OR DISAGREEMENT ARISING OUT OF OR RELATING TO THIS INSURANCE COVERAGE, YOU OR YOUR REPRESENTATIVE SHALL SUBMIT AN APPEAL IN WRITING TO VALUE BENEFITS OF AMERICA CLAIMS REVIEW COMMITTEE, 15575 N 79TH PL, SUITE 100, SCOTTSDALE, AZ 85260. THE CLAIMS REVIEW COMMITTEE SHALL PROMPTLY RESPOND TO YOU IN WRITING.

IF YOU ARE NOT SATISFIED AFTER RECEIVING THE RESPONSE, YOU AND THE COMPANY SHALL USE THEIR BEST EFFORTS TO SETTLE ANY DISPUTES AND SHALL NEGOTIATE IN GOOD FAITH TO REACH A JUST SOLUTION.

IF NO SATISFACTORY SOLUTION IS ACHIEVED BY THESE NEGOTIATIONS AS DESCRIBED ABOVE WITHIN 60 DAYS FROM THE DATE THE APPEAL IS RECEIVED; THEN UPON WRITTEN NOTICE BY YOU OR THE COMPANY, ALL DISPUTES, CLAIMS, QUESTIONS AND CONTROVERSIES OF ANY KIND OR NATURE ARISING OUT OF, OR RELATING IN ANY WAY TO, THIS INSURANCE COVERAGE, ITS SUBJECT MATTER, NEGOTIATION, ISSUANCE OR TERMINATION, OR THE RELATIONSHIPS LEADING TO OR RESULTING FROM THIS INSURANCE COVERAGE, OR THE VALIDITY OF THIS ARBITRATION PROVISION, SHALL BE SUBMITTED TO BINDING ARBITRATION PURSUANT TO THE PROVISIONS OF THE FEDERAL ARBITRATION ACT AND ACCORDING TO THE ARBITRATION RULES OF THE AMERICAN ARBITRATION ASSOCIATION THEN IN EFFECT. AN ARBITRATOR, WHO IS AN INDEPENDENT, NEUTRAL PARTY, WILL GIVE A DECISION AFTER HEARING THE POSITIONS OF THE PARTIES. UNDERSTANDING THAT PERSONS HAVE THE RIGHT OR OPPORTUNITY TO LITIGATE DISPUTES THROUGH A COURT, YOU AND THE COMPANY PREFER TO RESOLVE ANY DISPUTES THROUGH ARBITRATION, EXCEPT AS PROVIDED HEREIN. YOU AND THE COMPANY VOLUNTARILY AND KNOWINGLY WAIVE ANY RIGHT TO A JURY TRIAL AND PARTICIPATION IN ANY CLASS ACTION LAWSUITS. ARBITRATION TAKES THE PLACE OF RESOLVING DISPUTES BY A JUDGE AND JURY AND THE DECISION OF THE ARBITRATOR CANNOT BE REVIEWED IN COURT BY A JUDGE AND JURY.

(Arbitration Agreement continued on back page)

THE COST OF ALL ARBITRATION PROCEEDINGS SHALL BE ASSUMED BY THE COMPANY, WITH THE EXCEPTION OF THE COST OF YOUR REPRESENTATION. IF THE ARBITRATOR FINDS THAT THE DISPUTE IS WITHOUT SUBSTANTIAL JUSTIFICATION, THE ARBITRATOR HAS THE AUTHORITY TO ORDER THAT THE COST OF THE ARBITRATION PROCEEDINGS BE ASSUMED BY YOU.

ALL ARBITRATION PROCEEDINGS SHALL BE CONDUCTED IN YOUR COUNTY OF RESIDENCE UNLESS ANOTHER LOCATION IS MUTUALLY AGREED UPON BY BOTH PARTIES.

THE ARBITRATION PROCEEDINGS SHALL COMMENCE WITHIN 60 DAYS AFTER THE FIRST NOTIFICATION OF ONE PARTY BY THE OTHER AS TO THEIR ELECTION TO ARBITRATE A DISPUTE REGARDING THE POLICY.

PLEASE ACKNOWLEDGE BY SIGNING BELOW THAT YOU HAVE READ AND UNDERSTAND THE ARBITRATION AGREEMENT OUTLINED IN THIS ENDORSEMENT WHICH WILL BECOME PART OF YOUR INSURANCE CONTRACT.

SIGNATURE

DATE

PRINTED NAME

SOCIAL SECURITY NUMBER

**IMPORTANT NOTICE ABOUT THE INSURANCE COVERAGE
FOR WHICH YOU HAVE APPLIED**

THIS DOCUMENT AFFECTS YOUR LEGAL RIGHTS

READ THE FOLLOWING INFORMATION CAREFULLY

1. The insurance coverage for which you have applied includes a binding arbitration agreement.
2. The arbitration agreement requires that any disagreement related to this coverage must be resolved by arbitration and not in a court of law.
3. The results of the arbitration are final and binding on you and the insurance company.
4. In an arbitration, an arbitrator, who is an independent, neutral party, gives a decision after hearing the positions of the parties.
5. When you accept this insurance coverage by signing the attached Application and Endorsement, you agree to resolve any disagreement related to the coverage by binding arbitration instead of a trial in court including a trial by jury.
6. Arbitration takes the place of resolving disputes by a judge and jury and the decision of the arbitrator cannot be reviewed in court by a judge and jury.

ACKNOWLEDGMENT OF ARBITRATION AGREEMENT

I have read this statement. I understand that I am voluntarily surrendering my right to have any disagreement between the insurance company and myself resolved in court. This means I am waiving my right to a jury trial.

I understand that upon receipt of the policy or certificate, I should read the arbitration clause contained in the Endorsement which are a part of your policy or certificate, and that I have the right to reject this insurance coverage within [20 days] of the date of delivery if I do not want to accept the requirement for arbitration.

I understand that this same type of insurance may be available through an insurance company that does not require that the policy related disagreements be resolved by binding arbitration.

Applicant/Insured

Date

Agent

Date

Value Med Underwriting Guidelines

Application Question 1:

If "Yes" answer provide details. If the hospitalization or other confinement was due to a fracture, minor surgery (gall bladder, appendix, child birth), the applicant can qualify. If for 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.

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.

List Bill Cases

There is an additional Admin Fee of \$5.00 Monthly on all List Bill Cases of 2 or more, no matter what the group size.

HEIGHT & WEIGHT CHART

<u>FEMALE</u>			<u>MALE</u>		
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