Value Med Plan
for VBA Members

Sickness and Accident Office Call & Hospital Confinement Protection plus More

- NO DEDUCTIBLE OR CO-PAYS
- USE ANY DOCTOR OR HOSPITAL
- GUARANTEED RENEWABLE TO AGE 65

Benefits Are Paid Directly To You, In Addition To Any Other Insurance You May Have.

MEDICAL BENEFITS SCHEDULE

DOCTOR'S OFFICE CALLS

ANY LICENSED PROVIDER 10 per Calendar Year - Max 1 per Week	**$75.00 per visit**

OUTPATIENT BENEFIT

OUTPATIENT BENEFIT AMOUNT	**up to $250.00 per Visit**
Maximum Outpatient Calendar Year Benefit	**$1,000.00**

AMBULANCE

AMBULANCE BENEFIT per Sickness or Injury	**$200.00**

HOSPITAL BENEFIT

HOSPITAL BENEFIT AMOUNT Up to 365 Days LifetimeHospital Elimination Period - 3 Days	**$200.00 Daily**

Offered To VBA Members

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.

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, OK Policy Form U0552-OK.

Form ADH27-05

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.

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 VBA Membership. Classic Membership Fee is $5.00 Monthly.

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 A HOSPITAL CONFINEMENT INDEMNITY POLICY - FORM G0551-LA

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? ……… Ÿ Yes Ÿ 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? ……………… Ÿ Yes Ÿ 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? ……………… Ÿ Yes Ÿ 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 policy. (Attach additional signed & dated sheet if more room needed.)

Who Covered?	Replacing?	Company Name	Type of Coverage
œ A œ S	œ Yes œ No		
œ A œ S	œ Yes œNo		

PREMIUM

Applicant $____________________
Spouse $____________________
TOTAL PAYMENT DUE $____________________

Please make check/money order payable to:

GEM Administrators

Payment Mode: [Ÿ Annual Ÿ Semi-Annual Ÿ Quarterly Ÿ Monthly]

Billing Method: [Ÿ Direct Bill Ÿ Bank Draft Ÿ List Bill]

APPLICANT'S STATEMENTS

I HEREBY APPLY for an insurance policy 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 Policy is issued, and will be in force only as of the Policy 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 Policy; (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 presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

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 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.

HEIGHT & WEIGHT CHART

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

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 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.)	£ Monthly Bank Draft	£ Semi-Annual**	£ Annual**	£ Monthly List Bill
VBA Classic Membership Level (Required) - - - - - - - - - - -	$ 5.00*	$ 30.00*	$ 60.00*	$ 5.00*
VALUE HEALTH PLAN -	$______	$______	$______	$______
Value Health Plan Only $15.00 Monthly Admin Fee	$______	$______	$______	$______
VALUE MED PLAN -	$______	$______	$______	$______
TOTAL FOR ALL ABOVE -	$______	$______	$______	$______

***(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 Pl - #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:____________________