



SELECT BENEFIT SERVICES ASSOCIATION



Select Benefit Services Association

- + 24 HOUR ACCIDENT COVERAGE**
- + ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS**
- + LIFESTYLE DISCOUNTS AND SERVICES**

ADHV-28-10

GUARANTEE TRUST LIFE INSURANCE COMPANY (GTL)
1275 Milwaukee Avenue, Glenview, IL 60025
www.gtlic.com | 800.338.7452

(Rev. 11/21R) 15B942A

ACCIDENT ONLY INSURANCE OPTIONS

ISSUE AGES 18-69

	MONTHLY		MONTHLY
OPTION 1 <ul style="list-style-type: none"> \$2,500 Accident Medical Coverage - \$250 Deductible \$4,000 Emergency Air Ambulance \$2,500 Accidental Death and Dismemberment 	\$22 SINGLE \$40 FAMILY	OPTION 5 <ul style="list-style-type: none"> \$12,500 Accident Medical Coverage - \$250 Deductible \$4,000 Emergency Air Ambulance \$12,500 Accidental Death and Dismemberment 	\$41 SINGLE \$87 FAMILY
OPTION 2 <ul style="list-style-type: none"> \$5,000 Accident Medical Coverage - \$250 Deductible \$4,000 Emergency Air Ambulance \$5,000 Accidental Death and Dismemberment 	\$28 SINGLE \$54 FAMILY	OPTION 6 <ul style="list-style-type: none"> \$15,000 Accident Medical Coverage - \$250 Deductible \$4,000 Emergency Air Ambulance \$15,000 Accidental Death and Dismemberment 	\$42 SINGLE \$90 FAMILY
OPTION 3 <ul style="list-style-type: none"> \$7,500 Accident Medical Coverage - \$250 Deductible \$4,000 Emergency Air Ambulance \$7,500 Accidental Death and Dismemberment 	\$34 SINGLE \$68 FAMILY	OPTION 7 <ul style="list-style-type: none"> \$20,000 Accident Medical Coverage - \$250 Deductible \$4,000 Emergency Air Ambulance \$20,000 Accidental Death and Dismemberment 	\$45 SINGLE \$97 FAMILY
OPTION 4 <ul style="list-style-type: none"> \$10,000 Accident Medical Coverage - \$250 Deductible \$4,000 Emergency Air Ambulance \$10,000 Accidental Death and Dismemberment 	\$40 SINGLE \$82 FAMILY	OPTION 8 <ul style="list-style-type: none"> \$25,000 Accident Medical Coverage - \$250 Deductible \$4,000 Emergency Air Ambulance \$25,000 Accidental Death and Dismemberment 	\$48 SINGLE \$104 FAMILY

Your Monthly Rate Includes \$10.95 Membership Dues.

+ THE BENEFITS OF HAVING ACCIDENT INSURANCE

by Guarantee Trust Life Insurance Company

An accident can happen when you or one of your family members least expect it!

Guarantee Trust Life's 24 Hour Accident Coverage, accident only insurance, helps provide you with the comfort and the coverage you need for those unexpected expenses.

GTL's 24 Hour Accident Coverage has several options you can choose from.

+ BENEFIT DESCRIPTIONS

ACCIDENT MEDICAL COVERAGE

Any Doctor, Emergency Room, Clinic or Hospital

Medical Services means the Medically Necessary cost for: Treatment by a Doctor, nurse, dentist, hospital room and board, outpatient surgery, use of an Ambulance, dental work for Injury to sound and natural teeth, drugs, medicines, diagnostic tests and x-rays, oxygen, casts, splints, crutches, blood plasma, treatment performed by a licensed medical professional and the rental of durable medical equipment. Benefits are excess of other coverage.

Total medical expense benefits for a single Accident shall not exceed the maximum benefit amount per Injury shown in your certificate.

\$4,000 EMERGENCY AIR AMBULANCE

Many medical plans only cover ground Ambulance. In the event a member suffers from a covered Injury that requires emergency air Ambulance service we will reimburse the member up to the maximum amount of \$4,000.

ACCIDENTAL DEATH & DISMEMBERMENT (AD&D)

If a covered family member's Injury results in a loss, as defined in your certificate of coverage, within one year after the Accident causing the loss, we will pay benefits as described in your certificate of coverage for loss of life. Benefits for loss of limb and sight are also shown in the schedule of benefits.

AD&D benefits reduce by 50% on a Member's 70th birthday.

+ SELECT BENEFIT SERVICES ASSOCIATION

The following are included with all eight options:

TELADOC: SPEAK WITH A BOARD CERTIFIED PHYSICIAN BY PHONE OR VIDEO

With Teladoc, you can speak with a physician anytime, anywhere, 24 hours a day, 7 days a week, 365 days a year. A member can also access Teladoc through the mobile app and website. Call Teladoc and you can speak to a physician in most cases in less than 30 minutes. They can even provide a prescription if necessary. Please note a consult fee applies.

+ OTHER SBSA DISCOUNTS AND SERVICES

For a list of providers please visit www.selectbenefitservicesassociation.com

CAR RENTAL	Up to 15% year round discounts - Includes USA and Canada
HOTEL/MOTEL	Up to 60% at participating hotel and motel chains nationwide
FITNESS	Up to 50% off membership dues at more than 1,600 locations nationwide! Members also receive great discounts on a wide variety of products and services including sporting goods, magazines, gourmet foods and more
FLOWERS, GIFT BASKETS & MORE	20% off gift products including delicious gourmet baskets, sweet treats, heartwarming collectibles, beautiful flowers, plants and more
THEME PARKS	Receive exclusive discounts on Theme Park Tickets such as Walt Disney World®, Universal Parks®, Hershey Park, Legoland®, Six Flags® Nationwide, and many more
PHONES & TABLETS	Safe. Simple. Free. Save big with exclusive deals and earn cash back just for shopping at the same stores you are shopping at today
MOVIE TICKETS	Up to 40% off on movie tickets at many of the major movie theatre chains throughout the United States



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GTL'S 24 HOUR ACCIDENT INSURANCE COVERAGE DOES NOT PROVIDE BENEFITS FOR:

- Treatment, services or supplies which:
 - 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 (ATVs).
- 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.
- Repetitive motion injuries, strains, hernia, tendonitis, bursitis and heat exhaustion not related to a specific injury.

Please refer to your Certificate of Insurance and its Schedule of Benefits. There you will find a list of all Covered Charges, including those with maximum benefit amounts that differ from the overall plan maximums. These consist of Doctors' visits, Ambulance expense, dental treatment for injury to sound natural teeth, and chiropractic treatment.

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.

24 Hour Accident Coverage, accident only insurance, is issued on Policy Form MP-1300 by Guarantee Trust Life Insurance Company, Glenview, IL. This product and its features are subject to state availability and may vary by state. Certain exclusions and limitations may apply. For costs and complete details of the coverage, please read your certificate carefully.

Plan membership may be cancelled within the first 30 days and any premium paid will be fully refunded.

The Accident-Only Insurance by Guarantee Trust Life Insurance Company does not provide comprehensive health insurance coverage ("major medical coverage") nor does it satisfy the requirement of "minimum essential coverage" required under the Affordable Care Act.

Guarantee Trust Life Insurance Company and Select Benefit Services Association are separate legal entities and have sole financial responsibility for their own products.



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+ SELECT BENEFIT SERVICES ENROLLMENT FORM

MEMBER

LAST NAME _____ FIRST _____ INITIAL _____

SOCIAL SECURITY # _____ AGE (MAX. 69) _____ DATE OF BIRTH _____ HOME PHONE # _____

ADDRESS STREET _____ CITY _____ STATE _____ ZIP _____

E-MAIL ADDRESS FOR FULFILLMENT AND CORRESPONDENCE
Designated Beneficiary (Required for Member), Dependent's Beneficiary is Next of Kin:

LAST NAME _____ FIRST _____ INITIAL _____

FAMILY MEMBER ****List spouse (max age 69) and dependents (Max age 25)**

LAST NAME _____ FIRST _____ INITIAL _____

SOCIAL SECURITY # _____ AGE (MAX. 69) _____ DATE OF BIRTH _____ RELATIONSHIP _____

LAST NAME _____ FIRST _____ INITIAL _____

SOCIAL SECURITY # _____ AGE (MAX. 25) _____ DATE OF BIRTH _____ RELATIONSHIP _____

LAST NAME _____ FIRST _____ INITIAL _____

SOCIAL SECURITY # _____ AGE (MAX. 25) _____ DATE OF BIRTH _____ RELATIONSHIP _____

TERMS AND CONDITIONS

The Select Benefit Services Association (SBSA) is a membership organization committed to providing members high quality, innovative and money saving discounts and services. Membership privileges include the right to participate in all programs offered or sponsored by SBSA.

Member hereby requests enrollment in the Select Benefit Services Association. Member understands that the total monthly cost for the option selected includes the monthly premium for the 24 Hour Accident coverage and their monthly membership dues for their selected SBSA Membership.

Member hereby appoints SBSA president, or failing this person, a SBSA 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 SBSA, to the same extent and with the same powers as if the undersigned member were present at the meeting. Said proxy is to continue for a period of (1) year from date and is hereby renewed from year to year until the proxy is cancelled by writing delivered to the Association.

I agree to the terms and conditions of SBSA Membership as listed on this form.

X _____
SIGNATURE OF THE PRIMARY MEMBER ENROLLEE (written or electronic)

_____/_____/_____
DATE

***24 HOUR ACCIDENT COVERAGE OPTIONS PLEASE CHECK ONE**

(Includes \$10.95 Monthly Membership Dues):

- OPTION 1:** \$22.00 Single or \$40.00 Family
- OPTION 2:** \$28.00 Single or \$54.00 Family
- OPTION 3:** \$34.00 Single or \$68.00 Family
- OPTION 4:** \$40.00 Single or \$82.00 Family
- OPTION 5:** \$41.00 Single or \$87.00 Family
- OPTION 6:** \$42.00 Single or \$90.00 Family
- OPTION 7:** \$45.00 Single or \$97.00 Family
- OPTION 8:** \$48.00 Single or \$104.00 Family

**Monthly Rates*

*** (Includes civil union and domestic partners where authorized by state law)*

Member also understands that the insurance premiums and membership dues are refundable only within the first 30 days of receiving their coverage.

PLEASE COMPLETE FORM continued on the next page...

APPLICATION FOR GROUP ACCIDENT ONLY INSURANCE

THIS FORM MUST BE SIGNED BY THE APPLICANT AND SUBMITTED WITH THE ASSOCIATION ENROLLMENT FORM.

I agree to the voluntary purchase of the accident-only insurance program underwritten by Guarantee Trust Life Insurance Company, and made available to me through my membership in Select Benefit Services Association. I understand my Certificate of Insurance will provide a description of all the benefits, exclusions, terms and conditions of this coverage.

Any person who, with intent to defraud or knowing that s/he is facilitating fraud against an insurer, submits an application, enrollment or claim containing a false or deceptive statement may be guilty of insurance fraud as determined by a court of law.

X _____ /_____/_____
Signature of the Primary Member Enrollee (written or electronic) DATE

Designated Beneficiary (Required for Member), Dependent's Beneficiary is next of kin.

Last Name First Initial

EFACC-A-19

PAYMENT OPTIONS (CHECK ONE)

Make Payment to GTL

- Monthly Bank Draft Monthly List Bill (4 or More) *Billing will be in 15 days before due date*
 Credit Card Draft Date _____ Effective Date _____

REPRESENTATIVE NAME (Please print) REPRESENTATIVE NUMBER

Mail Policy to: Representative Insured

GTL AUTHORIZATION TO HONOR CHECKS, SHARE DRAFTS, OR ACCOUNT DEBITS

Name of Payor as it appears on Banking Institution Records:

LAST NAME FIRST INITIAL

ACCOUNT # ROUTING/TRANSIT #

BRANCH NAME OF BANKING INSTITUTION

ADDRESS CITY STATE ZIP

I authorize Guarantee Trust Life Insurance Company (GTL) to charge my account checks, share drafts, electronic fund transfer or debits, or other account debits made upon my account by and payable to the order of the entity designated above or its legal representative for membership, benefits and or insurance premiums. I agree that GTL's treatment of each check, share draft or debit, and GTL's 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 GTL will not be under any liability even though dishonor results in the forfeiture of insurance, benefits, or membership. I further agree that this authorization is to remain in effect until GTL receives written notice from me of its revocation unless GTL ends it earlier.

X _____ /_____/_____
SIGNATURE OF PAYOR DATE

ADDITIONAL SIGNATURE: NAME OF INSURED IF DIFFERENT FROM PAYOR (if joint account). DATE

CREDIT CARD AUTHORIZATION (Not applicable if paying by check or money order)

LAST NAME (ON CARD) FIRST INITIAL

BILLING ADDRESS CITY STATE ZIP

PHONE NUMBER CARD TYPE (check one) Discover VISA Master Card

I authorize Guarantee Trust Life Insurance Company to bill my VISA/ _____ /_____/_____
 MASTERCARD/ DISCOVER for my SBSA membership and insurance CARD NUMBER EXP. DATE
 plan(s) provided by Guarantee Trust Life Insurance Company.

This authorization is to remain in full force until Guarantee Trust Life Insurance Company has received written notification from me of its termination in such time and in such manner as to afford Guarantee Trust Life Insurance Company reasonable opportunity to act upon it.
 X _____ /_____/_____
SIGNATURE OF PAYOR DATE