

I hereby enroll for Full Associate membership in the FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS (FACT). Upon completion of this enrollment form and payment of initial dues (\$3 monthly), I understand that: (a) I will be entitled to FACT's benefits; (b) these benefits may change from time to time; (c) my membership will become effective on the day this enrollment form is dated and signed; (d) I am eligible to apply for association group insurance; and (e) I authorize the release of my name and address listed on the Golden Rule Insurance Company Application for Insurance to FACT.

Member's Signature X \_\_\_\_\_ Date X \_\_\_\_\_

FACT ENFO 0105

If you wish to apply for association group insurance, please complete the application below.

**GOLDEN RULE INSURANCE COMPANY  
APPLICATION FOR INSURANCE**

**MUST BE COMPLETED BY THE APPLICANT(S)**

**PLEASE PRINT IN BLACK INK**

**APPLICANT(S) INFORMATION**

1. **REASON FOR APPLICATION:**  New Application  Add a dependent ID Number \_\_\_\_\_  
 Child Only (list youngest child as the Primary Applicant)  Reinstatement  
 Change deductible (for additions, reinstatements, or deductible changes)

**2. PRIMARY APPLICANT'S INFORMATION:**

a. Name (Last, First, M.I.): \_\_\_\_\_

b. Mailing Address \_\_\_\_\_  
 Street (Include Apt.) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

c. **A physical address is required if it is different than your mailing address. P.O. Boxes are not accepted as a physical address.**

Physical Address \_\_\_\_\_  
 Street (Include Apt.) \_\_\_\_\_  
 City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

d. Phone Numbers: ( \_\_\_\_\_ ) ( \_\_\_\_\_ )  
 Home Other Best number and times to call E-mail Address \_\_\_\_\_

e. Payor: \_\_\_\_\_  
 (If not You): Name \_\_\_\_\_ E-mail Address \_\_\_\_\_  
 Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

f. Your Beneficiary: \_\_\_\_\_ You will be the beneficiary for your spouse.  
 Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_

g. Your Occupation: \_\_\_\_\_ h. Marital Status:  Married  Single

i. Total Annual Household Income:  \$15,000 or less  \$35,001 to \$50,000  \$75,001 to \$99,999  
 \$15,001 to \$35,000  \$50,001 to \$75,000  \$100,000 or more

**3. APPLICANTS FOR COVERAGE:** Please list only those persons needing coverage.

Gender	Name (Last, First, M.I.)	Social Security No.	Birth Date	Age	MUST BE ACCURATE	
					Height	Weight
<input type="checkbox"/> Male <input type="checkbox"/> Female	a. Primary (You)	_____	_____	_____	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female	b. Spouse	_____	_____	_____	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female	c. Child	_____	_____	_____	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female	d. Child	_____	_____	_____	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female	e. Child	NOT REQUIRED	_____	_____	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female	f. Child	_____	_____	_____	_____	_____
<input type="checkbox"/> Male <input type="checkbox"/> Female	g. Child	_____	_____	_____	_____	_____

If you need to list more dependents, please use lined paper, sign and date it, and check this box.



4. Primary Applicant's Mother's Maiden Name: \_\_\_\_\_ Spouse's Mother's Maiden Name: \_\_\_\_\_  
 (Last Name Only) (Last Name Only)
5. Do all of the applicants, other than the dependent children, read, write, speak, and understand the English language? . . . . .  Yes  No

**COVERAGE INFORMATION — Must complete for all new applications, including child only.**

6. Requested Effective Date: \_\_\_/\_\_\_/\_\_\_\_
7. All plans include a preferred network. Network Name: \_\_\_\_\_
8. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, indicate who below.) . . . . .  Yes  No  
**a. Primary b. Spouse c. Child d. Child e. Child f. Child g. Child**  
 Yes  Yes  Yes  Yes  Yes  Yes  Yes
9. Requested Health Class: Primary:  Preferred  Standard I  Standard II  
 Spouse:  Preferred  Standard I  Standard II
10. For additions and reinstatements, complete only if changing the deductible for all insureds.

**PRODUCT SELECTION & BILLING (or attach a health insurance quote)**

<input type="checkbox"/> Copay Select <sup>SM</sup> <input type="checkbox"/> Copay Saver <sup>SM</sup>  <input type="checkbox"/> \$ 500 (Copay Select only) <input type="checkbox"/> \$1,000 (Copay Select only) <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000  Coinsurance choices with Copay Select <input type="checkbox"/> 0% <input type="checkbox"/> 20% <input type="checkbox"/> 30%  <input type="checkbox"/> HSA 100® <input type="checkbox"/> HSA 70 <sup>SM</sup>  <table border="0"> <tr> <td>Single</td> <td>Family</td> </tr> <tr> <td><input type="checkbox"/> \$1,250</td> <td><input type="checkbox"/> \$2,500</td> </tr> <tr> <td><input type="checkbox"/> \$2,500</td> <td><input type="checkbox"/> \$5,000</td> </tr> <tr> <td><input type="checkbox"/> \$3,500</td> <td><input type="checkbox"/> \$7,000</td> </tr> <tr> <td><input type="checkbox"/> \$5,000</td> <td><input type="checkbox"/> \$10,000</td> </tr> </table> <input type="checkbox"/> Plan 100® <input type="checkbox"/> Plan 80 <sup>SM</sup> <input type="checkbox"/> Saver 80 <sup>SM</sup>  <input type="checkbox"/> \$ 500 (Saver 80 only) <input type="checkbox"/> \$1,000 (Saver 80 only) <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000	Single	Family	<input type="checkbox"/> \$1,250	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$7,000	<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000	FACT Dues \$ 3.00 Base Premium Amount + _____ <b>PLAN ENHANCEMENTS — See current brochure and inserts for availability</b> <input type="checkbox"/> \$5 Million Lifetime Maximum + _____ Optional <input type="checkbox"/> 24 Month Initial Rate Guarantee + _____ Optional <input type="checkbox"/> No Annual Maximum Prescription Drug + _____ Optional <input type="checkbox"/> \$25 Office Visit Copay + _____ Optional <input type="checkbox"/> 2 Additional Dr. Office Visits + _____ Optional <input type="checkbox"/> Prescription Drug Copay + _____ Optional <b>OPTIONAL BENEFITS — See current brochure and inserts for availability</b> <input type="checkbox"/> Enhanced Term Life: Primary <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 + _____ Optional <input type="checkbox"/> Enhanced Term Life: Spouse <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 + _____ Optional <input type="checkbox"/> Accidental Death: Primary + _____ Optional <input type="checkbox"/> Accidental Death: Spouse + _____ Optional <input type="checkbox"/> Supplemental Accident: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 + _____ Optional <input type="checkbox"/> Term Life + _____ Optional <input type="checkbox"/> Preventive Care + _____ Optional <input type="checkbox"/> UnitedHealthcare Dental: <input type="checkbox"/> Premier <sup>SM</sup> <input type="checkbox"/> Value <sup>SM</sup> (if available) + _____ Optional <input type="checkbox"/> UnitedHealthcare Vision (if available) + _____ Optional <input type="checkbox"/> HSA Deposit + _____ \$25 Monthly Min. <hr/> <b>Total Monthly Payment = \$ _____</b> One-Time HSA Set-Up Fee + _____ \$10 <input type="checkbox"/> One-Time HSA Indemnity Rider + _____ Optional <b>Initial Monthly Payment (Make check payable to "FACT") = \$ _____</b> <hr/> <b>If Quarterly, Total Monthly Payment x 3 = \$ _____</b> One-Time HSA Set-Up Fee + _____ \$10 <input type="checkbox"/> One-Time HSA Indemnity Rider + _____ Optional <b>Initial Quarterly Payment (Make check payable to "FACT") = \$ _____</b>
Single	Family										
<input type="checkbox"/> \$1,250	<input type="checkbox"/> \$2,500										
<input type="checkbox"/> \$2,500	<input type="checkbox"/> \$5,000										
<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$7,000										
<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000										

11. Initial Payment With Application (Premium will be verified and may be adjusted up or down during the underwriting process):  Check  EFT  Credit Card  
 Ongoing Payments: Monthly  EFT (no billing fee)  Direct Bill (\$10 monthly billing fee)  
 Quarterly  Direct Bill (\$10 quarterly billing fee)

**PREVIOUS OR CURRENT HEALTH INSURANCE COVERAGE (Completing this section may make you eligible for an earlier effective date for illnesses.)**

12. Within the last 63 days, has any applicant **been covered** by any type of **medical** insurance? Yes No  
   
 If yes, please complete chart below. Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced.

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Is this to be replaced?	Termination Date

13. Will the term life benefit replace any existing **life** insurance or annuities? Yes No

Insurance Company Name \_\_\_\_\_ Policy Number \_\_\_\_\_

14. If you have selected the optional dental and/or vision benefit, does any applicant have other dental and/or vision insurance that will not be replaced? Yes No  
   
 (The optional dental and/or vision benefit will not be issued to an applicant who has existing dental and/or vision insurance that is not being replaced.)

15. Has any applicant ever had an application or policy voided, declined, rated, or had coverage modified (including medical exclusion riders) by any health or life insurer? (If yes, list name and give details.) Yes No

Person: \_\_\_\_\_ Company: \_\_\_\_\_ Action Taken: \_\_\_\_\_

Date: \_\_\_\_\_ Reason for Action: \_\_\_\_\_

16. Has any applicant previously applied for, or been covered by, Golden Rule or UnitedHealthcare? Yes No

Name \_\_\_\_\_ Policy/Certificate Number \_\_\_\_\_

**DRIVING — FOR ALL APPLICANTS**

17. In the last 24 months, has any applicant participated in driving any type of motorcycle? Yes No

**If yes, please answer the following questions:**

- a. Which applicant(s)?  a. Primary  b. Spouse  c. Child  d. Child  e. Child  f. Child  g. Child
- b. Does applicant have a valid motorcycle license?  Yes  Yes  Yes  Yes  Yes  Yes  Yes
- c. Within the last 24 months, has the applicant had any motor vehicle license suspended or revoked? Yes No
- d. Within the last 24 months, has the applicant, while operating any motor vehicle, been involved in an accident or received a moving violation? If yes, provide details in "Medical History Details." Yes No

**MEDICAL HISTORY — FOR ALL APPLICANTS**

**IMPORTANT! YOU MUST PROVIDE DETAILS OF EACH YES ANSWER IN THE "MEDICAL HISTORY DETAILS" SECTION.**

18. Are you, or is any family member (whether or not named in this application), pregnant or an expectant mother or father; or in the process of a surrogate pregnancy; or do you or any family member have an adoption pending? Yes No
19. In the last 5 years, has any applicant filed a claim and/or received benefits from disability insurance or Worker's Compensation? Yes No
20. Has any applicant had or been advised to have: (a) any testing (other than routine testing, such as pap or mammogram); or (b) any treatment, which has not yet been completed? Yes No
21. In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind? Yes No
22. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more? Yes No
23. In the last 5 years, has any applicant used an illegal drug; had any diagnosis or treatment of an alcohol or drug dependency, problem, or abuse (not including membership in alcohol or drug dependency support groups); been advised to reduce alcohol intake; or had any alcohol- or drug-related moving violation, arrest, or driver's license suspension? Yes No
24. Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks\* per week? Yes No  
   
 If yes, show who and how many drinks\* per week in "Medical History Details" (\*one drink equals 12 oz. of beer, 4 oz. of wine, or 1 oz. of hard liquor).

**MEDICAL HISTORY — FOR ALL APPLICANTS (continued)**

25. In the last 5 years, has any applicant:
- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | Yes                      | No                       |
| a. Had a complicated pregnancy or delivery (including a caesarean section)?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Consulted a health-care provider for any condition or symptom(s) for which a diagnosis has not been established?  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Had any signs, symptoms, diagnosis, or treatment of Acquired Immune Deficiency Syndrome (AIDS) or any Human Immunodeficiency Virus (HIV)-related disease or illness; or tested positive for antibodies to the Human Immunodeficiency Virus (HIV)? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had any abnormal physical exam, X-ray, electrocardiogram (EKG), magnetic resonance imaging (MRI), computerized axial tomography scan (CAT or CT scan); or any adverse or abnormal laboratory or other test results?                               | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been confined in a hospital for anything other than childbirth?   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Had surgery?  | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Had placement, treatment, or maintenance of an internal or external implant or prosthetic device?   | <input type="checkbox"/> | <input type="checkbox"/> |

**In the last 5 years, has any applicant had testing or additional tests recommended for, or had any signs, symptoms, diagnosis, or treatment of, any disease, disorder, or abnormality of any of the following:**

- |  | Yes                      | No                       |   | Yes                      | No                       |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| <b>26. Digestive System</b>  |                          |                          | <b>33. Blood, Gland, Endocrine, or Metabolic</b>                              |                          |                          |
| a. gallbladder, pancreas, or liver?  | <input type="checkbox"/> | <input type="checkbox"/> | a. thyroid, breast, or other glands?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. ulcers?   | <input type="checkbox"/> | <input type="checkbox"/> | b. diabetes or sugar in the blood or urine?                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. gastroesophageal reflux disease (acid reflux, GERD)?  | <input type="checkbox"/> | <input type="checkbox"/> | c. anemia?  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. rectal bleeding?  | <input type="checkbox"/> | <input type="checkbox"/> | d. immune system disorder (other than AIDS or HIV)?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| e. other digestive system disorder or condition?   | <input type="checkbox"/> | <input type="checkbox"/> | e. other blood, endocrine, or metabolic disorder or condition?                | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>27. Urinary System</b>  |                          |                          | <b>34. Brain and Nervous System</b>   |                          |                          |
| a. kidney?   | <input type="checkbox"/> | <input type="checkbox"/> | a. migraines or chronic or severe headaches?                                  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. other urinary system disorder or condition?   | <input type="checkbox"/> | <input type="checkbox"/> | b. seizures or epilepsy?  | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>28. Eyes, Ears, Nose</b>  |                          |                          | c. mental, emotional, or behavioral disorder (including anorexia or bulimia)? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. ear or sinus infections (more than two in the past 12 months)?  | <input type="checkbox"/> | <input type="checkbox"/> | d. multiple sclerosis or paralysis?   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. other disorder or condition of the eyes, ears, or nose?   | <input type="checkbox"/> | <input type="checkbox"/> | e. other brain or nervous system disorder or condition?                       | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>29. Mouth, Throat, or Jaw</b>   | <input type="checkbox"/> | <input type="checkbox"/> | <b>35. Muscular or Skeletal System</b>  |                          |                          |
| <b>30. Skin Disorders</b>  | <input type="checkbox"/> | <input type="checkbox"/> | a. joints, bones, spine, or back?   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>31. Heart or Circulatory System</b>   |                          |                          | b. arthritis or fibromyalgia?   | <input type="checkbox"/> | <input type="checkbox"/> |
| a. chest pain?   | <input type="checkbox"/> | <input type="checkbox"/> | c. amputation?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. high or low blood pressure?   | <input type="checkbox"/> | <input type="checkbox"/> | d. other muscular/skeletal system disorder or condition?                      | <input type="checkbox"/> | <input type="checkbox"/> |
| c. elevated cholesterol?   | <input type="checkbox"/> | <input type="checkbox"/> | <b>36. Respiratory System</b>   |                          |                          |
| d. stroke?   | <input type="checkbox"/> | <input type="checkbox"/> | a. asthma or allergies?   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. shunts, stents, or pacemaker?   | <input type="checkbox"/> | <input type="checkbox"/> | b. sleep apnea?   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. other heart or circulatory system disorder or condition?  | <input type="checkbox"/> | <input type="checkbox"/> | c. other respiratory system disorder or condition?                            | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>32. Male or Female Reproductive System</b>  |                          |                          | <b>37. Cancer, Cyst, or Tumor</b>   |                          |                          |
| a. infertility or erectile dysfunction?  | <input type="checkbox"/> | <input type="checkbox"/> | a. cancer?  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. sexually transmitted disease?   | <input type="checkbox"/> | <input type="checkbox"/> | b. tumor, cyst, polyp, lump, or growth of any kind?                           | <input type="checkbox"/> | <input type="checkbox"/> |
| c. abnormal mammogram or Pap smear?  | <input type="checkbox"/> | <input type="checkbox"/> | <b>38. Birth Defects or Congenital Abnormalities</b>                          |                          |                          |
| d. other male or female reproductive system disorder or condition?   | <input type="checkbox"/> | <input type="checkbox"/> | a. Down's syndrome?   | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | b. cerebral palsy?  | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          | c. other birth defect or congenital abnormality?                              | <input type="checkbox"/> | <input type="checkbox"/> |
|  |                          |                          |   |                          |                          |
|  |                          |                          |   | Yes                      | No                       |
| 39. In the last 5 years, has any applicant had any signs, symptoms, diagnosis, or treatment for any other disease, disorder, injury, or condition (excluding childbirth) that is not listed on this application? | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |

Please list in "Medical History Details" any additional doctors or other health-care professionals that any applicant has consulted with or been treated by in the last 5 years, and give full details.

**MEDICAL HISTORY DETAILS — FOR ALL APPLICANTS**

Question Number: \_\_\_\_\_ Person: \_\_\_\_\_ Dates: \_\_\_\_\_

Symptoms or Conditions: \_\_\_\_\_  
\_\_\_\_\_

Prescriptions (include dose, how often taken, dates taken): \_\_\_\_\_  
\_\_\_\_\_

Treatment, Advice Given, Results, and Other Details: \_\_\_\_\_  
\_\_\_\_\_

Name, Address, Phone of Doctors, Hospitals, etc.: \_\_\_\_\_  
\_\_\_\_\_

Question Number: \_\_\_\_\_ Person: \_\_\_\_\_ Dates: \_\_\_\_\_

Symptoms or Conditions: \_\_\_\_\_  
\_\_\_\_\_

Prescriptions (include dose, how often taken, dates taken): \_\_\_\_\_  
\_\_\_\_\_

Treatment, Advice Given, Results, and Other Details: \_\_\_\_\_  
\_\_\_\_\_

Name, Address, Phone of Doctors, Hospitals, etc.: \_\_\_\_\_  
\_\_\_\_\_

Question Number: \_\_\_\_\_ Person: \_\_\_\_\_ Dates: \_\_\_\_\_

Symptoms or Conditions: \_\_\_\_\_  
\_\_\_\_\_

Prescriptions (include dose, how often taken, dates taken): \_\_\_\_\_  
\_\_\_\_\_

Treatment, Advice Given, Results, and Other Details: \_\_\_\_\_  
\_\_\_\_\_

Name, Address, Phone of Doctors, Hospitals, etc.: \_\_\_\_\_  
\_\_\_\_\_

Question Number: \_\_\_\_\_ Person: \_\_\_\_\_ Dates: \_\_\_\_\_

Symptoms or Conditions: \_\_\_\_\_  
\_\_\_\_\_

Prescriptions (include dose, how often taken, dates taken): \_\_\_\_\_  
\_\_\_\_\_

Treatment, Advice Given, Results, and Other Details: \_\_\_\_\_  
\_\_\_\_\_

Name, Address, Phone of Doctors, Hospitals, etc.: \_\_\_\_\_  
\_\_\_\_\_

If you need more space to provide complete and accurate information, please use lined paper, sign and date it, and check this box.

**SPECIAL INSTRUCTIONS**

**STATEMENT OF UNDERSTANDING — Please review the completed application and read the section below carefully before signing.**

I personally completed this application. I represent that the answers and statements on it are true, complete, and correctly recorded. **I understand and agree that:**

- (1) This application and the initial payment do not give me immediate coverage.
- (2) I should not terminate existing coverage until I have accepted the Golden Rule coverage.
- (3) Unless Golden Rule agrees to an earlier date, coverage for illness begins on the 15th day after a person becomes insured for injury.
- (4) There will be no benefits for any loss incurred in the first year of coverage due to a preexisting condition, except when this time period is reduced due to qualifying prior coverage.
- (5) **Incorrect or incomplete information on this application may result in voidance of coverage and claim denial.**
- (6) This completed application, and any supplements or amendments, will be a part of any policy or certificate, if issued.
- (7) The broker may only submit the application and initial payment. The broker may not promise me coverage; modify Golden Rule's underwriting policy or terms of coverage; or change or waive any right or requirement.
- (8) The broker may receive copies of any correspondence about my medical history when correspondence is required.
- (9) **If I continue other coverage existing on the Golden Rule effective date for more than 90 days after that date, the Golden Rule coverage will be void.**
- (10) I must notify Golden Rule of any medical conditions or treatment arising between the date of this application and the effective date of my coverage.
- (11) I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding all listed dependents. The results of my investigation are disclosed to the best of my knowledge.
- (12) If Golden Rule rejects this application, under no circumstances will any benefits be payable. Receipt of money, cashing of my check, or charging my credit card by Golden Rule does not constitute approval of my application or create Golden Rule coverage.
- (13) Golden Rule may request additional information, and this may delay the processing of this application. If the health-care provider charges a fee for these services, Golden Rule will determine its payment, and I will be responsible for any difference.
- (14) Golden Rule has the right to rely upon the answers and statements in this application, without requesting medical records from any provider listed.

I have received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

X \_\_\_\_\_  
Primary Applicant (You)

X \_\_\_\_\_  
Parent/Guardian (If you are a minor) Relationship

X \_\_\_\_\_  
Spouse (If to be covered)

\_\_\_\_\_  
Date

**BROKER STATEMENT: Please review the completed application before signing below.**

I verify that each question on the application was completed by the applicant(s). The applicant has received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

- 1. I agree with the answer given for Question 13, "Will the term life benefit replace any existing **life** insurance or annuities?" (If the response for Question 13 does not reflect your understanding, please check this box and attach an explanation. )
- 2. I am not aware of any information that conflicts with the answers provided in this application.

X \_\_\_\_\_  
Signature of Licensed Broker

\_\_\_\_\_  
Broker Number

X \_\_\_\_\_  
Print Full Name

**HEALTH INSURANCE CERTIFICATION AND AUTHORIZATION TO OBTAIN AND DISCLOSE NONMEDICAL INFORMATION**

This insurance coverage is not designed nor marketed as employer-provided insurance. This coverage does not comply with all your state's small-employer group health insurance laws. Therefore, this plan cannot be used, now nor at some future date, by you or an employer to provide insurance for employees.

I certify that:

- (a) No portion of the premium is paid, either directly or indirectly, by my employer; and
- (b) I am not treating the insurance as part of a plan under section 106, 125, or 162 of the United States Internal Revenue Code.

By signing below, I certify that I understand that I am applying for personal health insurance that may never be used as employer-provided insurance.

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain information that they need to underwrite or verify my application for insurance. Any employer, insurance company, government agency, consumer-reporting agency,

or the Medical Information Bureau (MIB) having information about my occupation(s), avocations, driving history, criminal history, or prior insurance coverage for my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments.

Golden Rule may also release this information about my family or me to the MIB or any member company for the purposes described in Golden Rule's Notice of Information Practices.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to Golden Rule. I (we) may request revocation of this authorization by writing to Golden Rule, as explained in Golden Rule's Notice of Information Practices. Golden Rule may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

**I have read the above: Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.**

Signed X \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ at \_\_\_\_\_ City State  
Date

X \_\_\_\_\_  
Signature of Primary Applicant (You)

X \_\_\_\_\_  
Signature of Parent/Guardian (If You are a minor)

X \_\_\_\_\_  
Signature of Spouse (If to be covered)

36231-0107

**AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION**

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain health information that they need to underwrite or verify my application for insurance. Any health-care provider, consumer-reporting agency, the Medical Information Bureau (MIB), or insurance company having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments. This includes information related to substance use or abuse.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

Golden Rule may release this information about my family or me to the MIB or any member company for the purposes described in Golden Rule's Notice of Information Practices.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

I (we) understand the following:

- A photocopy of this authorization is as valid as the original;
- I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to Golden Rule;
- I (we) may request revocation of this authorization as described in Golden Rule's Notice of Information Practices;
- Golden Rule may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization;
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.

I have retained a copy of this authorization.

**I have read the above: Authorization to Obtain and Disclose Health Information.**

Signed X \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ at \_\_\_\_\_ City State  
Date

X \_\_\_\_\_  
Signature of Primary Applicant (You)

X \_\_\_\_\_  
Signature of Parent/Guardian (If You are a minor)

X \_\_\_\_\_  
Signature of Spouse (If to be covered)

36228-0208

**HEALTH SAVINGS ACCOUNT (HSA) APPLICATION (only if opening an HSA with OptumHealth Bank)**

By signing to the right, I acknowledge that:

- I wish to establish a health savings account (HSA) with OptumHealth Bank as custodian.
- I understand the eligibility requirements for deposits made to my HSA and state that I qualify to make deposits to this account. I have reviewed this application and understand and agree that my HSA will be opened under and governed by OptumHealth Bank's Custodial and Deposit Agreement and that the terms and conditions therein will be binding on me. This document will be sent to me when my account is opened, along with OptumHealth Bank's Privacy Policy and Schedule of Fees.
- I authorize OptumHealth Bank to provide information about my HSA, including my account number, to Golden Rule, and those acting on behalf of Golden Rule or OptumHealth Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that Golden Rule and all others acting on behalf of Golden Rule, may provide information on my behalf to establish and maintain my HSA and authorize Golden Rule and its designee to take such action deemed necessary and appropriate by Golden Rule to administer my HSA, including but not limited to, making deposits and correcting errors where necessary.
- I understand my monthly account statements will be made available to me electronically. I agree to notify OptumHealth Bank if I wish to have statements mailed to my home address.
- I have requested a MasterCard Prepaid Debit Card and if I have filled out the information to request an Authorized User debit card, I hereby request OptumHealth Bank to issue a debit card on my account to the person indicated and I acknowledge I will be liable for the use of the debit card by the Authorized User.
- I authorize OptumHealth Bank to share information about my HSA with the Authorized User named and to allow any account transactions made by such Authorized User.
- I certify that the information provided in this application is true and complete.

X \_\_\_\_\_

Signature of Primary Applicant

Primary Applicant's Social Security Number \_\_\_\_\_

Applicant's Spouse Social Security Number \_\_\_\_\_

**Per the USA Patriot Act:** To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

**REQUEST FOR AN AUTHORIZED USER DEBIT CARD (OPTIONAL)**

Authorized User's \_\_\_\_\_  
 First Name Middle Initial

Authorized User's \_\_\_\_\_  
 Last Name

Authorized User's \_\_\_\_\_  
 Date of Birth

Authorized User's \_\_\_\_\_  
 Social Security No.

155X-1108

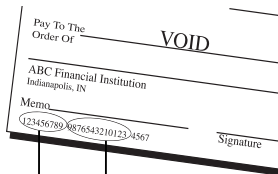
**ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION — ONLY IF PAYING BY EFT**

I (we) hereby authorize FACT or Golden Rule to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account. I agree this authorization will remain in effect until you actually receive written notification of its termination from me.

Type of Account:  Checking  Savings

Nine-digit Routing No. \_\_\_\_\_

Account No. \_\_\_\_\_



Financial Institution's Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Draft On \_\_\_\_\_

Day

Date Signed

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date; or 2) up to 10 days after the due date.

X \_\_\_\_\_

Authorized Account Signature

E-mail Address \_\_\_\_\_

**INITIAL PAYMENT CREDIT CARD AUTHORIZATION**

I authorize FACT or Golden Rule to bill my MasterCard/Visa account for the Initial Payment. **If quarterly billing requested, the Initial Payment will be for three months plus any one-time costs.**

Type of Card:  MasterCard  Visa Exp. Date: \_\_\_\_\_  
 Month Year

Name as Printed on Card: \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Card Number: \_\_\_\_\_

X \_\_\_\_\_  
 Signature of Authorized User

NOTE: Some card issuers/financial institutions charge cash advance fees on insurance payments.



**PART III Application (You must sign and date in one of the boxes below if you signed under B. in Part I.)**

**Applying for a Portability Plan (guaranteed-issue coverage)**

I signed under B. in Part I because all six statements under Part I apply to me. While I understand that Golden Rule makes the final determination regarding eligibility, I am applying for a portability plan. My signature below confirms that my portability rights were explained, and the minimum and maximum rates were made available to me.

X \_\_\_\_\_  
Signature of Proposed Insured

X \_\_\_\_\_  
Date

**Not Applying for a Portability Plan (guaranteed-issue coverage)**

Even though I believe I am eligible for a portability plan, I am not applying for a portability plan. My signature below confirms that my portability rights were explained; portability coverage was offered; the minimum and maximum rates were made available, and I do not wish to pursue this option at this time.

I realize if I am eligible and I do not apply for a portability plan within 63 days of losing my group coverage, this right may no longer be available to me.

X \_\_\_\_\_  
Signature of Proposed Insured

X \_\_\_\_\_  
Date

**Part IV Proof of Creditable Coverage (Complete only if you are applying for a portability plan.)**

**Option 1**

**OR**

**Option 2**

- 1) Provide the information requested below; and
- 2) Provide copies of "certificates of creditable coverage" as evidence of coverage under each health plan for the past 18 months. *Certificates of creditable coverage* are available from your prior health insurance administrators.

- 1) Provide the information requested below; and
- 2) Provide copies of "supporting documents" as evidence of coverage under each health plan for the past 18 months. *Supporting documents* may include copies of the following: identification card, explanation of benefits, pay stubs showing a deduction for health coverage, insurance certificate, and/or cancelled premium payment checks.

**Details About Your Most Recent Coverage**

Most Recent Employer Name and Address		Employment Termination Date		Phone No.
Most Recent Insurance Company Name and Address		Effective Date	Termination Date	ID No. Phone No.
Other Insurance Companies for the Past 18 Months		Effective Date	Termination Date	ID No. Phone No.