



**COVERAGE INFORMATION**

11. Requested Effective Date: \_\_\_/\_\_\_/\_\_\_ Requested Health Class: Primary:  Preferred  Standard  Tobacco (if question 30 is yes)  
 Plan includes Preferred Network; if not wanted, check here  Spouse:  Preferred  Standard  Tobacco (if question 30 is yes)  
 Network Name: \_\_\_\_\_

<b>Copay Plans</b>	<input type="checkbox"/> Copay Select <sup>SM</sup> <input type="checkbox"/> \$ 500	<b>HSA Plans</b>	Single <input type="checkbox"/> HSA 100 <sup>SM</sup> <input type="checkbox"/> \$1,050 <input type="checkbox"/> Family <input type="checkbox"/> \$ 2,100	<b>High Deductible</b>	<input type="checkbox"/> \$ 500 (Saver 80 only)
	<input type="checkbox"/> \$1,000		<input type="checkbox"/> \$1,800 <input type="checkbox"/> \$ 3,650		<input type="checkbox"/> \$1,000 (Saver 80 only)
	<input type="checkbox"/> \$1,500		<input type="checkbox"/> \$ 5,450		<input type="checkbox"/> \$1,500 (Saver 80 only)
	<input type="checkbox"/> \$2,500		<input type="checkbox"/> \$2,700 <input type="checkbox"/> \$ 7,500		<input type="checkbox"/> \$2,500
	<input type="checkbox"/> Copay Saver <sup>SM</sup> <input type="checkbox"/> \$2,000		<input type="checkbox"/> \$3,500 <input type="checkbox"/> \$10,000		<input type="checkbox"/> \$3,500
			<input type="checkbox"/> \$5,000		<input type="checkbox"/> \$5,000
<b>Optional</b>	<input type="checkbox"/> Term Life Benefit	<b>Optional</b>	<input type="checkbox"/> Term Life Benefit	<b>Optional</b>	<input type="checkbox"/> Term Life Benefit <input type="checkbox"/> Preventive Care
	<input type="checkbox"/> Preventive Care (Not Available with Copay Select)		<input type="checkbox"/> Preventive Care		<input type="checkbox"/> Supplemental Accident
	<input type="checkbox"/> Supplemental Accident		<input type="checkbox"/> Hospital Indemnity Rider		<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 Maximum Maternity
	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 Maximum Maternity				<input type="checkbox"/> Prescription Drug Card (Not Available with Saver 80)

**BILLING (or attach health insurance quote)**

12. Initial Payment With Application  
 Check  P.A.C. (EFT with on-line app. only)  Credit Card →

**Ongoing Payments**

Monthly P.A.C. (EFT)  Quarterly Direct Bill  List Bill (include forms)

FACT Dues	\$ 3.00	
Base Premium Amount	+	
Term Life Benefit	+	Optional
Preventive Care	+	Optional
Supplemental Accident	+	Optional
Maternity Benefit	+	Optional
Prescription Drug Card	+	Optional
HSA Deposit	+	\$25 Monthly Minimum (only with HSA)
<b>Total Monthly Payment</b>	= \$	
One-Time HSA Set-Up Fee	+	\$10 only with HSA
One-Time HSA Indemnity Rider	+	
<b>Initial Payment</b>	= \$	Make check payable to "FACT."

**Initial Payment Credit Card Authorization**

I authorize FACT or Golden Rule to bill my Visa/MasterCard 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 Expiration Date: \_\_\_\_\_  
 Month Year

Security Code \_\_\_\_\_ (last 3 digits in signature line)

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

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

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

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

<b>Total Monthly Payment</b>	= \$	→ <b>If Quarterly</b>	→ X3 = \$	<b>Total Quarterly Payment</b>
One-Time HSA Set-Up Fee	+		+	One-Time HSA Set-Up Fee
One-Time HSA Indemnity Rider	+		+	One-Time HSA Indemnity Rider
<b>Initial Payment</b>	= \$	Make check payable to "FACT."	= \$	<b>Initial Payment</b> ←

**OTHER COVERAGE**

13. Within the last 62 days, has any applicant **been covered by** any type of **medical** insurance? If yes, complete chart below. Yes  No   
**Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced (see (7) above the signature lines).**

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

14. Will the term life benefit replace any existing **life** insurance? Company Name \_\_\_\_\_ Policy # \_\_\_\_\_ Yes  No

15. Has any applicant ever had an application or policy, voided, declined, postponed, rated, or charged an extra premium, 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? Yes  No   
 If yes, who? \_\_\_\_\_ Policy/Certificate # \_\_\_\_\_

**DRIVING**

- Yes No
17. In the last 24 months, has any applicant participated in driving any type of motorcycle?
- If yes, please answer the following questions:**
- a. Name of applicant(s)? \_\_\_\_\_
- b. Does the applicant have a valid motorcycle license?
- c. Within the last 24 months, has the applicant had his/her license suspended or revoked?
- d. Within the last 24 months, has the applicant, while operating a motor vehicle, been involved in an accident or received a moving violation? If yes, provide details in "Medical History Details."

**MEDICAL HISTORY -- FOR ALL APPLICANTS**

IMPORTANT! PLEASE PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS."

- |   | Yes | No |   | Yes | No |
|---|-----|----|---|-----|----|
| 18. Is any family member (whether or not named in this application) pregnant or an expectant mother or father? <input type="checkbox"/> <input type="checkbox"/>                                      |     |    | 24. <b>In the last 10 years, has any applicant:</b>   |     |    |
| 19. Do any applicants, other than dependent children, <b>not</b> read, write, speak, and understand the English language? <input type="checkbox"/> <input type="checkbox"/>                           |     |    | a. had a complicated pregnancy or delivery? <input type="checkbox"/> <input type="checkbox"/>   |     |    |
| 20. Do you have an adoption pending? <input type="checkbox"/> <input type="checkbox"/>  |     |    | b. tested positive for antibodies to the HIV virus? <input type="checkbox"/> <input type="checkbox"/>   |     |    |
| 21. <b>In the last 6 months</b> , has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind? <input type="checkbox"/> <input type="checkbox"/> |     |    | c. been hospital confined, had surgery, or discussed surgery? <input type="checkbox"/> <input type="checkbox"/>   |     |    |
| 22. <b>Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:</b>  |     |    | 25. <b>In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:</b>  |     |    |
| a. gallbladder? <input type="checkbox"/> <input type="checkbox"/>   |     |    | a. heart or circulatory system? <input type="checkbox"/> <input type="checkbox"/>   |     |    |
| b. pancreas or liver? <input type="checkbox"/> <input type="checkbox"/>   |     |    | b. nervous system? <input type="checkbox"/> <input type="checkbox"/>  |     |    |
| c. joints or spine? <input type="checkbox"/> <input type="checkbox"/>   |     |    | c. digestive system? <input type="checkbox"/> <input type="checkbox"/>  |     |    |
| d. kidney? <input type="checkbox"/> <input type="checkbox"/>  |     |    | d. muscular or skeletal system? <input type="checkbox"/> <input type="checkbox"/>   |     |    |
| e. eyes, ears, or nose? <input type="checkbox"/> <input type="checkbox"/>   |     |    | e. respiratory system? <input type="checkbox"/> <input type="checkbox"/>  |     |    |
| f. mouth, throat, or jaw? <input type="checkbox"/> <input type="checkbox"/>   |     |    | f. male or female reproductive system, including infertility? <input type="checkbox"/> <input type="checkbox"/>   |     |    |
| 23. <b>In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:</b>   |     |    | g. urinary system? <input type="checkbox"/> <input type="checkbox"/>  |     |    |
| a. high blood pressure? <input type="checkbox"/> <input type="checkbox"/>   |     |    | h. thyroid, breast, or other glands? <input type="checkbox"/> <input type="checkbox"/>  |     |    |
| b. chest pain? <input type="checkbox"/> <input type="checkbox"/>  |     |    | 26. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any other disease, disorder, injury, or adverse finding, or had any adverse or abnormal test results? <input type="checkbox"/> <input type="checkbox"/> |     |    |
| c. headaches? <input type="checkbox"/> <input type="checkbox"/>   |     |    | 27. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more? <input type="checkbox"/> <input type="checkbox"/>  |     |    |
| d. paralysis? <input type="checkbox"/> <input type="checkbox"/>   |     |    | 28. In the last 5 years, has any applicant had any indication, diagnosis, or treatment of an alcohol or drug dependency, problem, or abuse; or any alcohol- or drug-related arrest? <input type="checkbox"/> <input type="checkbox"/>                               |     |    |
| e. arthritis? <input type="checkbox"/> <input type="checkbox"/>   |     |    | 29. Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks per week? <input type="checkbox"/> <input type="checkbox"/>   |     |    |
| f. convulsions or epilepsy? <input type="checkbox"/> <input type="checkbox"/>   |     |    | 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; 1 oz. of hard liquor).   |     |    |
| g. elevated cholesterol? <input type="checkbox"/> <input type="checkbox"/>  |     |    | 30. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, mark "Tobacco" in Question 11.) <input type="checkbox"/> <input type="checkbox"/>                      |     |    |
| h. sexually transmitted disease? <input type="checkbox"/> <input type="checkbox"/>  |     |    | 31. 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.  |     |    |
| i. cancer? <input type="checkbox"/> <input type="checkbox"/>  |     |    |   |     |    |
| j. diabetes or sugar in the blood or urine? <input type="checkbox"/> <input type="checkbox"/>   |     |    |   |     |    |
| k. stroke? <input type="checkbox"/> <input type="checkbox"/>  |     |    |   |     |    |
| l. Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness? <input type="checkbox"/> <input type="checkbox"/>  |     |    |   |     |    |
| m. tumor, cyst, polyp, lump, or growth of any kind? <input type="checkbox"/> <input type="checkbox"/>   |     |    |   |     |    |
| n. mental, emotional, or behavioral disorder? <input type="checkbox"/> <input type="checkbox"/>   |     |    |   |     |    |



**MONTHLY P.A.C. AUTHORIZATION -- ONLY IF PAYING BY MONTHLY P.A.C.**

I (we) hereby authorize FACT or Golden Rule to initiate debit entries to the account indicated below. I also authorize the named depository to debit the same to such account.

I agree this authorization will remain in effect until you actually receive written notification from me (or either of us) of its termination.

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

X \_\_\_\_\_  
(Signature of Account Holder)

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

Address \_\_\_\_\_

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

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

X \_\_\_\_\_  
(Date Signed)

**Include Voided BLANK check!**

**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) I am not employed by an employer with 2-50 employees; or
- (b) I am employed by an employer with 2-50 employees; however, no portion of the premium is paid, either directly or indirectly, by my employer.

If you cannot certify to either (a) or (b) above, you are not eligible to apply for this plan.

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.

953B-799

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 person,

employer, insurance company, consumer-reporting agency, or the Medical Information Bureau (MIB) having nonmedical information about 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

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

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

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

**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, 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

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

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

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

**BROKER STATEMENT: Review the completed application before signing below**

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.

I agree with the answer given for Question 14, "Will the term life benefit replace any existing life insurance?" (If the response shown for Question 14 does not reflect your understanding, please check this box and attach an explanation. )

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

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

**HEALTH SAVINGS ACCOUNT (HSA) AGREEMENT AND ADOPTION (only if depositing HSA money with Golden Rule)**

I wish to establish an HSA with Golden Rule as custodian. This HSA will be exclusively for the purpose of paying or reimbursing qualified medical expenses of me, my spouse, and dependents.

I represent that I am eligible to contribute to this HSA. Specifically, I:

- 1) am covered by (or have applied for) a Golden Rule high deductible health plan (HDHP);
- 2) am not also covered by any other health plan that is not an HDHP (except for permitted insurance or coverage allowed by law);
- 3) am not enrolled in Medicare; and
- 4) cannot be claimed as a dependent on another person's tax return.

I adopt the current Golden Rule HSA Custodial Agreement and agree to its terms. I understand the following:

- 1) Golden Rule has no responsibility for the tax treatment of my HSA.
- 2) I may revoke the HSA Custodial Agreement for any reason within seven days after I receive a copy of the HSA Custodial Agreement.
- 3) If the HSA Custodial Agreement is revoked by me, I will not be charged a set-up fee nor any monthly fees and agree that no interest will be paid on the money returned.
- 4) Golden Rule will set up my HSA and begin crediting interest the later of: a) 10 days after issue of the HDHP; or b) the effective date of my HDHP.
- 5) Interest will not begin to accrue until funds are deposited with Golden Rule's agent bank.
- 6) The HSA Custodial Agreement and Disclosure Statement is subject to change and may be changed as necessary to comply with the law.

**If my spouse has also signed this agreement, I authorize my spouse to withdraw funds from my HSA.**

**Required Certification:** Under penalties of perjury, I certify that (1) my Social Security number below is correct; and (2) I am not subject to back-up withholding and elect not to have any withholding apply. (Cross out and initial (2) if you have been notified that you were subject to backup withholding.)

Have you, within the last 6 months, been covered under another health insurance plan?  Yes  No Has your spouse?  Yes  No

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

X \_\_\_\_\_  
Signature of Primary Applicant

X \_\_\_\_\_  
Signature of Spouse (if authorized to withdraw HSA funds)

**If your spouse is not applying for an HDHP but is authorized to withdraw HSA Funds:**

Spouse's Printed Name \_\_\_\_\_

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

Spouse's Date of Birth \_\_\_\_\_

**REVIEW BEFORE MAILING THE APPLICATION**

**Be sure:**

- To read the current product brochure before completing the application for insurance.

**Note:**

- If you were previously insured by UnitedHealthcare, you must still fully complete this application accurately. Our underwriters do not have access to UnitedHealthcare underwriting and claims files.
- Broker must be licensed with Golden Rule in state where application is signed AND state where applicant resides.
- Coverage is not available if:
  - any family member is currently pregnant; or
  - the applicant has not resided in the U.S. for the last 12 consecutive months.
- Altered applications will not be accepted.
- Any person who knowingly presents false, incomplete, or misleading information in an application for insurance may be committing insurance fraud.

- The applicant will be notified of the actions taken within 45 days after the date of the application, or be given the reason for delay.
- There is no coverage until approved in writing by Golden Rule.
- **P.O. Boxes are not accepted as a Primary Resident Address.**
- **Applications received by Golden Rule more than 15 days after the signed date will not be accepted.**

**Mail the Application and Related Forms Packet to the address below.**

**Be sure to include the following:**

- Health Insurance Illustration.
- Initial payment check made payable to "FACT."
- P.A.C. authorization and voided check (if paying monthly).

**Mail to:** Golden Rule Insurance Company  
HEALTH APPLICATION  
Home Office  
712 Eleventh Street  
Lawrenceville, Illinois 62439-2395