FACT MEMBERSHIP ENROLLMENT FORM

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 ______________

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

FACT ENFO 0105

GOLDEN RULE INSURANCE COMPANY
APPLICATION FOR INSURANCE

To be filled out personally by the applicant(s) **PLEASE PRINT IN BLACK INK** **Do not separate application pages**

APPLICANT(S) INFORMATION (Only list persons applying for coverage)

	Name (Last, First, M.I.)	Marital Status	Social Security Number	Birth Date	Age	Sex	Height	Weight
1. Primary (You)		❑ M ❑ S						
2. Spouse								

3. Dependent Children	Name (Last, First, M.I.)		Birth Date	Age	Sex	Height	Weight
a.		Not Required					
b.							
c.							
d.							
e.							

4. Primary Applicant's Address **(P.O. Boxes are not accepted.)**

____
Street City State ZIP

5. Phone Numbers: ( ) ( ) ______________
Daytime Evening Best times to call

6. Payor ______________________________
(If not You): Name Street City State ZIP

7. Your Beneficiary: ______________________________ You will be the beneficiary for your spouse.
Name Relationship Age

8. Your Occupation: ____________ Date Hired: ____________

Prior Employment (If within 2 years): ____________

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

10. Primary Applicant's Mother's Maiden Name: ____________ Spouse's Mother's Maiden Name: ____________

COVERAGE INFORMATION

11. **Requested Effective Date:** __ __/__ __/__ __ __ __ **Requested Health Class:** Primary: ❑ Preferred ❑ Standard ❑ Tobacco (if question 31 is yes)
Plan includes Preferred Network; if not wanted, check here ❑ Spouse: ❑ Preferred ❑ Standard ❑ Tobacco (if question 31 is yes)

HSA Plans

Single/Family

- ❑ HSA 100℠
- ❑ HSA Saver℠
- ❑ $1,000/$2,000
- ❑ $1,750/$3,550
- ❑ $2,650/$5,250
- ❑ $3,500/$7,500
- ❑ $5,000/$10,000

Optional
- ❑ Term Life Benefit
- ❑ Preventive Care
- ❑ Hospital Indemnity Rider

High Deductible

- ❑ Plan 100®
- ❑ Plan 80℠
- ❑ Saver 80℠
- ❑ $1,000
- ❑ $1,500
- ❑ $2,500
- ❑ $3,500
- ❑ $5,000
- ❑ $500 (*Saver 80* only)

Optional
- ❑ Term Life Benefit ❑ Preventive Care
- ❑ Supplemental Accident
- ❑ $2,500 ❑ $4,000 Maximum Maternity
- ❑ Prescription Drug Card (Not Available with *Saver 80*)

Copay Plans

- ❑ Copay 25℠
- ❑ Copay 35℠
- ❑ $500
- ❑ $750
- ❑ $1,250
- ❑ Copay Saver℠ ❑ $2,000

Optional
- ❑ Term Life Benefit
- ❑ Preventive Care
- ❑ Supplemental Accident
- ❑ $2,500 ❑ $4,000 Maximum Maternity

The plans listed above, except the Saver Plans, provide coverage for prescription contraceptive drugs and devices. If you want to reject this coverage because it is contrary to your moral, ethical, or religious beliefs, please check this box ❑.

BILLING (or attach health insurance illustration)

12. **Initial Payment With Application**
- ❑ Check
- ❑ Credit Card

Ongoing Payments
- ❑ Monthly P.A.C.
- ❑ Quarterly Direct Bill →
- ❑ List Bill (include list-bill 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)				
Total Monthly Payment	= $ ____	→ **If Quarterly** →	**X3**	= $ ____	**Total Quarterly Payment**	
One-Time HSA Set-Up Fee	+ ____	$10 only with HSA		+ ____	One-Time HSA Set-Up Fee	
One-Time HSA Indemnity Rider	+ ____			+ ____	One-Time HSA Indemnity Rider	
Initial Payment	= $ ____	Make check payable to "FACT."		= $ ____	**Initial Payment** ←	

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 credit cardholder

OTHER COVERAGE

	Yes	No
13. Within the last 62 days, has any applicant **been covered by** any type of **medical** insurance? If yes, complete chart below. .... **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

	Yes	No
14. Will the term life benefit replace any existing **life** insurance? Company Name ____________ Policy # ________	❑	❑
15. Has any applicant ever had an application or policy 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.)	❑	❑

Person: ____________ Company: ____________ Action Taken: ____________

Date: ____________ Reason for Action: ____________

	Yes	No
16. Has any applicant previously applied for, or been covered by, Golden Rule? .... 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
18.	Is any family member (whether or not named in this application) pregnant or an expectant mother or father?	❑	❑
19.	Do any applicants, other than dependent children, **not** read, write, speak, and understand the English language?	❑	❑
20.	Do you have an adoption pending?	❑	❑
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?	❑	❑
22.	**Within the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:**		
	a. gallbladder?	❑	❑
	b. pancreas or liver?	❑	❑
	c. joints or spine?	❑	❑
	d. kidney?	❑	❑
	e. eyes, ears, or nose?	❑	❑
	f. mouth, throat, or jaw?	❑	❑
23.	**In the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of:**		
	a. high blood pressure?	❑	❑
	b. chest pain?	❑	❑
	c. headaches?	❑	❑
	d. paralysis?	❑	❑
	e. arthritis?	❑	❑
	f. convulsions or epilepsy?	❑	❑
	g. elevated cholesterol?	❑	❑
	h. sexually transmitted disease?	❑	❑
	i. cancer?	❑	❑
	j. diabetes or sugar in the blood or urine?	❑	❑
	k. stroke?	❑	❑
	l. tumor, cyst, polyp, lump, or growth of any kind?	❑	❑
	m. mental, emotional, or behavioral disorder?	❑	❑
24.	**In the last 10 years, has any applicant:**		
	a. had a complicated pregnancy or delivery?	❑	❑
	b. tested positive for antibodies to the HIV virus?	❑	❑
	c. been hospital confined, had surgery, or discussed surgery?	❑	❑
25.	**In the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:**		
	a. heart or circulatory system?	❑	❑
	b. nervous system?	❑	❑
	c. digestive system?	❑	❑
	d. muscular or skeletal system?	❑	❑
	e. respiratory system?	❑	❑
	f. male or female reproductive system, including infertility?	❑	❑
	g. urinary system?	❑	❑
	h. thyroid, breast, or other glands?	❑	❑
26.	In the last 10 years, has any applicant had any diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness?	❑	❑
27.	In the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of any other disease, disorder, injury, or adverse finding, or had any adverse or abnormal test results?	❑	❑
28.	In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more?	❑	❑
29.	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?	❑	❑
30.	Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks per week? 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).	❑	❑
31.	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.)	❑	❑
32.	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	Symptoms or Condition	Dates	Treatment, Advice Given, Results, and Other Details	Name, Address, and Phone # of Doctors, Hospitals, etc.

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

STATEMENT OF UNDERSTANDING: Review the completed application and read the section below carefully before signing.

I certify that I have personally completed this application. I represent that the answers and statements on this application are true, complete, and correctly recorded. **I Understand and Agree** that: **(1)** this application and the payment of the initial premium do not give me immediate coverage; **(2)** unless Golden Rule agrees to an earlier date, coverage for illness begins on the 15th day after a person becomes insured for injury; **(3)** there will be no benefits for any loss incurred in the first year of coverage due to a preexisting condition; **(4) incorrect or incomplete information on this application may result in voidance of coverage or claim denial; (5)** this completed application, and any supplements or amendments, will be made a part of any policy/certificate which may be issued; **(6)** the broker is only authorized to submit the application and initial premium, and may not change or waive any right or requirement; and **(7) continuation of other coverage existing on the Golden Rule effective date for more than 90 days after the Golden Rule effective date will void this coverage.** I have received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

Signed X ______/______/______ at ______________________________ X ______________________________
Date City State Signature of Primary Applicant (You)

X ______________________________ X ______________________________
Signature of Parent/Guardian (if You are a minor) Relationship Signature of Spouse (if to be covered)

This form must be signed and returned to GOLDEN RULE INSURANCE COMPANY with all applications.

MISSOURI PORTABILITY CERTIFICATION

INSTRUCTIONS (You may be eligible for a portability plan -- guarantee issue without preexisting conditions limits.)

PART I Review the statements and sign where appropriate.
PART II, PART III, PART IV Review and complete only if you sign under B. in Part I.

PART I ELIGIBILITY INFORMATION (Decide whether or not all of the statements 1-6 apply to you.)

1. I do not have any other health insurance coverage (or it will be involuntarily terminated soon).
2. I have been insured by *creditable coverage*[1] (as defined below) for the last 18 months or more with no lapse in coverage of more than 63 days.
3. My most recent coverage was under a *group health plan*[2] (as defined below), a governmental plan, or a church plan.
4. My most recent coverage was not terminated due to nonpayment of premiums, fraud, or intentional misrepresentations.
5. I am not eligible for any coverage under a *group health plan*[2] (as defined below), Medicare, or Medicaid.
6. I accepted and exhausted any group continuation of coverage (including COBRA) that was offered to me -- or -- I was not offered group continuation of coverage (including COBRA).

Carefully review the statements above and sign below where appropriate.

A. One or more of the six statements above **do not** apply to me.

Signature ______________________ Date ______________

If you signed under A, go to page 7.

— OR —

B. I represent that all six of the statements above **do** apply to me.

Signature ______________________ Date ______________

If you signed under B, answer the questions below and complete the rest of this form.

How many employees work for the employer that most recently provided your health insurance?............................... ________

Were you eligible for COBRA or group continuation of coverage? .... ❑ YES ❑ NO

If yes, did you maintain COBRA or group continuation until it expired?.. ❑ YES ❑ NO

PART II PLAN DESIGN, PRICE, AND AVAILABILITY (Plan 100®, Preferred Network, $1,500 or $2,500 deductible)

How does portability affect plan design?

Portability plans: 1) do not include a 12-month rate guarantee; 2) do not apply preexisting conditions limitations; 3) do not offer the optional benefits typically available with the plan; and 4) have higher premium rates.

What happens if a family applies and not all are eligible for portability?

Those who are eligible will be considered for a portability plan, and those not eligible will be subject to underwriting for a plan without portability rights.

How are premiums calculated?

Initial rates are higher for portability plans. Rates may increase substantially (up to 200%) after underwriting -- see the Sample Calculation.

What if only one or two family members want to apply for a portability plan and the others want to be underwritten for a plan without portability rights?

Complete two separate applications, and we will consider the family members under two separate plans. Children are not required to apply with their parent, but may apply separately.

Sample Calculation:

- Plan 100®, Preferred Network
- $1,500 deductible male
- Single, age 55
- Standard Health Class
- Missouri ZIP Code 63001
- July 2005 Effective Date

Base Rate (preferred)	$362.00
Health Class Factor	x 1.10
	$398.20
Quarterly Trend Factor	x 1.050
	$418.11
Area Factor	x .72
	$301.04
Preexisting Waiver Factor	x 1.10
Monthly Total (minimum)	$331.14 *
	x 2.00
Monthly Total (maximum)	$662.29 *

* Rate is for illustration purposes only.

[1] *Creditable coverage* includes group or individual health insurance coverage, Medicare, Medicaid, Armed Forces coverage, Indian or tribal coverage, state risk pool coverage, public health coverage, and Peace Corps Act coverage. A plan is NOT *creditable coverage* if it: a) provides coverage only for accidents, disability, or liability; b) is credit-only insurance; or c) is secondary to other insurance.

[2] Generally, a *group health plan* is any coverage existing in connection with employment. Included are employer-sponsored plans (so long as at least one employee participates); coverage of an employee under an individual policy of insurance that is part of a plan, fund, or program established or maintained by an employer that provides medical care to employees or their dependents; coverage of a business owner so long as at least one employee other than the business owner and the business owner's spouse also participates in the plan; and coverage of partners in a plan maintained by the partnership.

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 ______________________________ X ______________________________
Signature of Proposed Insured 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 ______________________________ X ______________________________
Signature of Proposed Insured Date

PART IV PROOF OF CREDITABLE COVERAGE (Complete ONLY if you are applying for a portability plan.)

Option 1

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.

OR

Option 2

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.**

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)

Attach Voided BLANK check here!

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 ________________
Date 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 ________________
Date 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

X ______________________________
Print Full Name

Broker Number

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 shown on the application is correct; and (2) I am not subject to backup 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

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

Spouse's Social Security Number ___ ___ ___ – ___ ___ – ___ ___ ___ ___

Spouse's Date of Birth ______________________________

X ______________________________
Signature of Primary Applicant

X ______________________________
Signature of Spouse

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 (UHC), you must still fully complete this application accurately. Our underwriters do not have access to UHC 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

047D-0105

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