

QuotesforMedical.com

Application Instructions for Golden Rule

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to QuotesforMedical.com for review along with the completed application. If you do not have access to a fax machine, send the completed application to QuotesforMedical.com along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must complete, sign, and date the authorization form.

Don't forget to enclose the initial payment check made payable to:

- "FACT" for all states except CT, DE, GA, KS, KY, LA, NV, NM, SD, and WY
- "Golden Rule" for CT, DE, GA, KS, KY, LA, NV, NM, SD, and WY only

Mail completed applications and check to:

QuotesforMedical.com
Attn: New Enrollment
100 W. Roosevelt Rd
Bldg 8, Ste 103A
Wheaton, IL 60187

QuotesforMedical.com will review your application for completeness and accuracy before we submit it to Golden Rule for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 1-866-522-5953 or e-mail us at info@QuotesforMedical.com.

Norvax form #IN-1

QuotesforMedical.com

Application Process FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

****Please FAX this cover letter with the completed application to:**

QuotesforMedical.com

FAX# 630-480-3346

Dear QuotesforMedical.com,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number _____
after you have reviewed my application for completeness and accuracy.

I will contact QuotesforMedical.com at 1-866-522-5953 to verify receipt of my application.

****I understand that QuotesforMedical.com will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to QuotesforMedical.com. I will mail the original signed application to :

QuotesforMedical.com

Attn: New Enrollment

100 W. Roosevelt Rd

Bldg 8, Ste 103A

Wheaton, IL 60187

I will send the original application as soon as I have been contacted by QuotesforMedical.com with confirmation that my application has been received by fax and reviewed for completeness.

Norvax form #CS-1

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)	<input type="checkbox"/> M <input type="checkbox"/> S	_ _ _ _ _ _ _ _ _ _ _	_ _ _ _	_	_	_ _	_ _
2. Spouse		_ _ _ _ _ _ _ _ _ _ _	_ _ _ _	_	_	_ _	_ _
3. Dependent Children			Birth Date	Age	Sex	Height	Weight
a. Name (Last, First, M.I.)							
b.							
c.							
d.							
e.							

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

_____ Street (Include Apt.) _____ City _____ State _____ ZIP _____

5. Phone Numbers: () () _____ Best number and times to call _____ E-mail Address _____

Home Other

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

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

8. Your Occupation: _____ Date Hired: _____ 9. Total Annual _____ \$15,000 or less \$35,001 to \$50,000 \$75,001 to \$99,999
 Prior Employment (If within 2 years): _____ Household Income: \$15,001 to \$35,000 \$50,001 to \$75,000 \$100,000 or more

10. Primary Applicant's Mother's Maiden Name: _____ (Last Name Only) Spouse's Mother's Maiden Name: _____ (Last Name Only)

Primary Applicant's initials _____ Spouse's initials _____ Date ____/____/____



COVERAGE INFORMATION

11. Requested Effective Date: ___/___/_____ Special Instructions: _____
 All plans include a preferred network; if not wanted, check here Network Name: _____
Requested Health Class: Primary: Preferred Standard I Standard II
 Spouse: Preferred Standard I Standard II
Tobacco Use: **Primary** Yes **Spouse** Yes **Child a.** Yes **Child b.** Yes **Child c.** Yes **Child d.** Yes **Child e.** Yes (See Question 32 for applicants age 18 and older, including dependent children).

AVAILABLE PRODUCTS

HIGH DEDUCTIBLE PLANS

- Plan 100[®] \$ 500 (Saver 80 only)
- Plan 80SM \$1,000 (Saver 80 only)
- Saver 80SM \$1,500 \$2,500 \$3,500 \$5,000

COPAY PLANS

- Copay SelectSM \$ 500 (Copay Select only) \$1,000 (Copay Select only)
- Copay SaverSM \$1,500 \$2,500 \$5,000

HSA PLANS

	Single 2008	Family 2008
<input type="checkbox"/> HSA 100 [®]	<input type="checkbox"/> \$1,100 <input type="checkbox"/> \$1,900 <input type="checkbox"/> \$2,900	<input type="checkbox"/> \$2,200 <input type="checkbox"/> \$3,850 <input type="checkbox"/> \$5,800
<input type="checkbox"/> HSA Saver [®]	<input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000

OPTIONAL BENEFITS

- Enhanced Term Life - Primary \$50,000 \$100,000 \$150,000
- Enhanced Term Life - Spouse \$50,000 \$100,000 \$150,000
- Accidental Death Benefit - Primary
- Accidental Death Benefit - Spouse
- Lifetime Maximum - \$5 Million
- Maternity (not available with HSA Plans)
- Supplemental Accident (not available with HSA Plans): \$500 \$1,000
- Preventive Care (not available with Copay Select)
- 2 Additional Dr. Visits a Year (Copay Saver only)
- Prescription Drug - no annual max. (Copay Select only)
- Prescription Drug Card (Plan 100 and Plan 80 only)
- HSA Hospital Indemnity Rider (not available with \$1,100 or \$2,200 deductibles)
- UnitedHealthcare Dental: PremierSM ValueSM (if available)
- Vision Benefit (if available)

BILLING (or attach health insurance quote)

12. **Initial Payment With Application:** Check EFT Credit Card
Ongoing Payments: Monthly (EFT) Quarterly Direct Bill
 FACT Dues \$ 3.00
 Base Premium Amount + _____
 Enhanced Term Life - Primary + _____ Optional
 Enhanced Term Life - Spouse + _____ Optional
 Accidental Death - Primary + _____ Optional
 Accidental Death - Spouse + _____ Optional
 Lifetime Maximum - \$5 Million + _____ Optional
 Maternity Benefit + _____ Optional
 Supplemental Accident + _____ Optional
 Preventive Care + _____ Optional
 2 Additional Dr. Visits a Year + _____ Optional
 Prescription Drug - no annual max. + _____ Optional
 Prescription Drug Card + _____ Optional
 Dental (if available) + _____ Optional
 Vision (if available) + _____ Optional
 HSA Deposit + _____ \$25 Monthly Minimum
 (only with HSA)
 Child(ren) Admin. Fee + _____ \$5 Monthly
 (only if primary applicant <18 yrs)

Total Monthly Payment = \$ _____
 One-Time HSA Set-Up Fee + _____ \$10 (only with HSA)
 One-Time HSA Indemnity Rider + _____ Optional (only with HSA)
Initial Payment = \$ _____ Make check payable to "FACT."

If Quarterly, Total Monthly Payment x 3 = \$ _____
 One-Time HSA Set-Up Fee + _____ \$10 (only with HSA)
 One-Time HSA Indemnity Rider + _____ Optional (only with HSA)
Initial Payment = \$ _____ Make check payable to "FACT."

IMPORTANT: Premium will be verified and may be adjusted up or down during the underwriting process.

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?
If yes, who? _____ Policy/Certificate # _____

DRIVING -- FOR ALL APPLICANTS

17. In the last 24 months, has any applicant participated in driving any type of motorcycle?

If yes, please answer the following questions:

- a. Which applicant(s)? Primary Spouse Child a. Child b. Child c. Child d. Child e.
- b. Does applicant have a valid motorcycle license? Yes Yes Yes Yes Yes Yes
- c. Within the last 24 months, has the applicant had any motor vehicle license suspended or revoked?
- 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."

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"/>	25. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:		
19. Do any applicants, other than dependent children, not read, write, speak, and understand the English language?	<input type="checkbox"/>	<input type="checkbox"/>	a. heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>
20. Do you have an adoption pending?	<input type="checkbox"/>	<input type="checkbox"/>	b. nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>	c. digestive system?	<input type="checkbox"/>	<input type="checkbox"/>
22. Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:			d. muscular or skeletal system?	<input type="checkbox"/>	<input type="checkbox"/>
a. gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>	e. respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
b. pancreas or liver?	<input type="checkbox"/>	<input type="checkbox"/>	f. male or female reproductive system, including infertility?	<input type="checkbox"/>	<input type="checkbox"/>
c. joints or spine?	<input type="checkbox"/>	<input type="checkbox"/>	g. urinary system?	<input type="checkbox"/>	<input type="checkbox"/>
d. kidney?	<input type="checkbox"/>	<input type="checkbox"/>	h. thyroid, breast, or other glands?	<input type="checkbox"/>	<input type="checkbox"/>
e. eyes, ears, or nose?	<input type="checkbox"/>	<input type="checkbox"/>	26. In the last 10 years, has any applicant had any diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS)?	<input type="checkbox"/>	<input type="checkbox"/>
f. mouth, throat, or jaw?	<input type="checkbox"/>	<input type="checkbox"/>	27. In the last 10 years, has any applicant had a persistent, recurrent fever greater than 100 degrees Fahrenheit for 3 weeks or more, unexplained chronic fatigue for one month or more, night sweats for one month or more, or a chronic cough for one month or more?	<input type="checkbox"/>	<input type="checkbox"/>
23. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:			28. 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"/>
a. high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	29. 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"/>
b. chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	30. 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"/>
c. headaches?	<input type="checkbox"/>	<input type="checkbox"/>	31. 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"/>
d. paralysis?	<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).		
e. arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	32. 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"/>
f. convulsions or epilepsy?	<input type="checkbox"/>	<input type="checkbox"/>	33. 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.		
g. elevated cholesterol?	<input type="checkbox"/>	<input type="checkbox"/>			
h. sexually transmitted disease?	<input type="checkbox"/>	<input type="checkbox"/>			
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. tumor, cyst, polyp, lump, or growth of any kind?	<input type="checkbox"/>	<input type="checkbox"/>			
m. mental, emotional, or behavioral disorder?	<input type="checkbox"/>	<input type="checkbox"/>			
24. In the last 10 years, has any applicant:					
a. had a complicated pregnancy or delivery?	<input type="checkbox"/>	<input type="checkbox"/>			
b. been hospital confined, had surgery, or discussed surgery?	<input type="checkbox"/>	<input type="checkbox"/>			

BROKER STATEMENT: Review the completed application before signing below

Each question on the application was completed by the applicant(s). I have collected the initial premium and given the Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

X _____
Signature of Licensed Broker

8860014

Broker Number

GRI-AP-107-21

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 Mike Novelli
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) 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 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 _____
Date City State
X _____
Signature of Parent/Guardian (If you are a minor)

X _____
Signature of Primary Applicant (You)
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, 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 _____
Date City State
X _____
Signature of Parent/Guardian (If you are a minor)

X _____
Signature of Primary Applicant (You)
X _____
Signature of Spouse (If to be covered)

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 an HSA with OptumHealth Bank as custodian.
- I understand and agree that my HSA will be opened under and governed by OptumHealth Bank's Custodial and Deposit Agreement. Terms of this Agreement will be binding on me unless I close my account within 30 days. This document will be sent to me when my account is opened, along with OptumHealth Bank's Privacy Policy and Schedule of Fees and Charges.
- 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 (if applicable), may provide information on my behalf to establish and maintain my HSA.
- 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.
- If I have filled out the information to request an additional 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 withdrawals by check, debit card, or other means to be 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 NumberSpouse's
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 InitialAuthorized User's _____
Last NameAuthorized User's _____
Date of BirthAuthorized User's _____
Social Security No.

155X-0108

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 depository 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.

Nine-digit Check Routing No. _____

Checking
Acct. 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

Signature of Account Holder

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.**

Name as Printed on Card: _____

Billing Address _____

City _____

State _____

ZIP _____

Type of Card: MasterCard Visa Expiration Date: _____
Month Year

Card Number: _____

X

Signature of Authorized User

REVIEW BEFORE MAILING THE APPLICATION

- Please 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.
- Coverage is not available if 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.
- You 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.
- **Applications received by Golden Rule more than 15 days after the signed date will not be accepted.**

Mail this Application Packet with the following:

- Health insurance quote.
- Initial payment:
 - Check made payable to "FACT";
 - EFT authorization (if paying via EFT); or
 - Credit card authorization (if paying via credit card).

Mail to: Golden Rule Insurance Company
HEALTH APPLICATION
PO Box 68994
Indianapolis, Indiana 46268-0994