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**

| 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 (Include Apt.) City State ZIP

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

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: ______

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 $99,99 ❑ $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 ___/___/___

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11. Requested Effective Date: ___/___/______

All plans include a preferred network.

Special Instructions: ____________________

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 31 for applicants age 18 and older, including dependent children.)

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**❑ Copay Select℠**
**❑ Copay Saver℠**

❑ $ 500 (*Copay Select* only)
❑ $1,000 (*Copay Select* only)
❑ $1,500 ❑ $2,500 ❑ $5,000
❑ $7,500 ❑ $10,000

Coinsurance choices with *Copay Select*
❑ 0% ❑ 20% ❑ 30%

**❑ HSA 100®**
**❑ HSA 70℠**

| Single | Family |
|---|---|
| ❑ $1,250 | ❑ $2,500 |
| ❑ $2,500 | ❑ $5,000 |
| ❑ $3,500 | ❑ $7,000 |
| ❑ $5,000 | ❑ $10,000 |

**❑ Plan 100®**
**❑ Plan 80℠**
**❑ Saver 80℠**

❑ $ 500 (*Saver 80* only)
❑ $1,000 (*Saver 80* only)
❑ $1,500 ❑ $2,500 ❑ $5,000
❑ $7,500 ❑ $10,000

| | | |
|---|---|---|
| FACT Dues | $ 3.00 | |
| Base Premium Amount | + ______ | |
| **PLAN ENHANCEMENTS — See current brochure and inserts for availability** | | |
| ❑ $5 Million Lifetime Maximum | + ______ | Optional |
| ❑ 24 Month Initial Rate Guarantee | + ______ | Optional |
| ❑ No Annual Maximum Prescription Drug | + ______ | Optional |
| ❑ $25 Office Visit Copay | + ______ | Optional |
| ❑ 2 Additional Dr. Office Visits | + ______ | Optional |
| ❑ Prescription Drug Copay | + ______ | Optional |
| **OPTIONAL BENEFITS — See current brochure and inserts for availability** | | |
| ❑ Enhanced Term Life: Primary ❑ $50,000 ❑ $100,000 ❑ $150,000 | + ______ | Optional |
| ❑ Enhanced Term Life: Spouse ❑ $50,000 ❑ $100,000 ❑ $150,000 | + ______ | Optional |
| ❑ Accidental Death: Primary | + ______ | Optional |
| ❑ Accidental Death: Spouse | + ______ | Optional |
| ❑ Supplemental Accident: ❑ $500 ❑ $1,000 | + ______ | Optional |
| ❑ Term Life | + ______ | Optional |
| ❑ Maternity Benefit | + ______ | Optional |
| ❑ Preventive Care | + ______ | Optional |
| ❑ UnitedHealthcare Dental: ❑ Premier℠ ❑ Value℠ (if available) | + ______ | Optional |
| ❑ UnitedHealthcare Vision (if available) | + ______ | Optional |
| ❑ HSA Deposit | + ______ | $25 Monthly Mi |
| **Total Monthly Payment** | = $ ______ | |
| One-Time HSA Set-Up Fee | + ______ | $10 |
| ❑ One-Time HSA Indemnity Rider | + ______ | Optional |
| **Initial Monthly Payment** (Make check payable to "FACT") | = $ ______ | |
| **If Quarterly, Total Monthly Payment x 3** | = $ ______ | |
| One-Time HSA Set-Up Fee | + ______ | $10 |
| ❑ One-Time HSA Indemnity Rider | + ______ | Optional |
| **Initial Quarterly Payment** (Make check payable to "FACT") | = $ ______ | |

12. **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)

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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. .................... Yes ❑ No ❑

| 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.) .................... ❑ ❑
Person: Company: Action Taken:
Date: Reason for Action:

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16. Has any applicant previously applied for, or been covered by, Golden Rule? ❑ Yes ❑ No
If yes, who? ______________ Policy/Certificate # ______________

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)? ❑ **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 ❑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." ❑ ❑

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

**Note: You need not reveal HIV tests or the results of HIV tests. You need not reveal genetic tests or the results of genetic tests.**

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 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 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. been hospital confined, had surgery, or scheduled or been advised to schedule surgery that has not yet been completed? ❑ ❑

Yes No

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:**
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 by a health care professional for Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness? (You need not reveal information about HIV tests.) ❑ ❑
27. 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? ❑ ❑
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. (This does not include consultations regarding AIDS-related testing.)

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| Question Number | Person | Symptoms or Conditions | Dates | Treatment, Advice Given, Results, and Other Details | Name, Address, and Phone # of Doctors, Hospitals, etc. |
|---|---|---|---|---|---|
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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 ________________________

Date City State

X ______________________________

Signature of Primary Applicant (You)

X ______________________________

Signature of Parent/Guardian (if You are a minor) Relationship

X ______________________________

Signature of Spouse (if to be covered)

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.

X ______________________________

Signature of Licensed Broker

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|

Broker Number

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 ______________________________

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 health 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.

I understand that my premium cannot be paid with an employer check unless I am certifying under (a) above.

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.

002C-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 ________________________________ X ________________________________

Date City State Signature of Primary Applicant (You)

X ________________________________ X ________________________________

Signature of Parent/Guardian (If you are a minor) Signature of Spouse (If to be covered)

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 ________________________________ X ________________________________

Date City State Signature of Primary Applicant (You)

X ________________________________ X ________________________________

Signature of Parent/Guardian (If you are a minor) Signature of Spouse (If to be covered)

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## 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 [ ]

Spouse'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 Initial

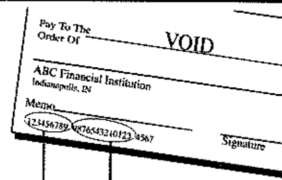
Authorized User's ______________________________
Last Name

Authorized User's ______________________________
Date of Birth

Authorized User's [ ]
Social Security No.

155X-1108

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 ______________________________

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

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

- 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.

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- 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





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