

I hereby apply 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; and (d) I am eligible to apply for Association Group insurance.

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

**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		M.I.	Marital Status	Social Security Number	Birth Date	Age	Sex	Height	Weight
Last	First								
1.			<input type="checkbox"/> M <input type="checkbox"/> S						
Primary (You)									
2.									
Spouse									
Name		M.I.			Birth Date	Age	Sex	Height	Weight
Last	First								
3.									
Dependent Children									
a.									
b.									
c.									
d.									

4. Primary Resident Address: \_\_\_\_\_  
 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: 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  \$35,001 to \$50,000  \$75,001 to \$99,999  
 \$15,001 to \$35,000  \$50,001 to \$75,000  \$100,000 or more

**BILLING (or attach software illustration).**

10.  Monthly P.A.C.  Quarterly  List Bill (include list-bill forms)

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

**Initial Premium and FACT dues Credit Card Authorization**

I authorize Golden Rule to bill my VISA/MASTERCARD account for initial Premium and FACT dues.  Visa  MasterCard Exp. Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_

X \_\_\_\_\_  
 Signature of credit cardholder

**Total Quarterly Payment** = \$ \_\_\_\_\_  
**One-Time MSA Set-Up Fee** + \_\_\_\_\_  
**MSA Indemnity Rider** + \_\_\_\_\_  
**Payment With Application** = \$ \_\_\_\_\_

**COVERAGE INFORMATION**

11. Plan:  Copay 25<sup>SM</sup> Plan  Copay 35<sup>SM</sup> Plan  Copay 45<sup>SM</sup> Plan  Plan 100<sup>®</sup>  Basic Plan<sup>SM</sup>  MSA 100<sup>®</sup> Plan  
 70/30  70/30  70/30  Plan 80<sup>SM</sup>  MSA 80<sup>SM</sup> Plan  
 50/50  50/50  50/50

Deductible: \_\_\_\_\_

- Optional Benefits:  Prescription Drug Card  Supplemental Accident  Term Life Rider  Maximum Maternity Benefit  
 \$2,500  \$4,000  
 MSA Indemnity Benefit

Requested Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

- Requested Health Class: Preferred Standard Tobacco (If question 26 is yes.)  
 Primary     
 Spouse

Requested PPO Option:  Full PPO

Special Instructions: \_\_\_\_\_

**OTHER COVERAGE**

12a. Within the last 62 days, has any applicant been covered by, or has application been made for, any type of medical insurance? If yes, .....  Yes  No  
 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

b. Will this plan replace any existing life insurance? Company Name \_\_\_\_\_ Policy # \_\_\_\_\_  Yes  No

c. 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

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

**DRIVING**

13. 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. Name of applicant(s)? \_\_\_\_\_  Yes  No  
 b. Does the applicant have a valid motorcycle license? .....  Yes  No  
 c. Within the last 24 months, has the applicant had his/her license suspended or revoked? .....  Yes  No  
 d. Within the last 24 months, has the applicant, while operating a motor vehicle, been involved in an accident or received a moving violation? .....  Yes  No

**MEDICAL HISTORY -- FOR ALL APPLICANTS**

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

<p>14. Is any family member (whether or not named in this application) pregnant or an expectant mother or father? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>15. Do any applicants, other than dependent children, <b>not</b> read, write, speak, and understand the English language? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>16. Do you have an adoption pending? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>17. In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>18. <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></p> <p>a. gallbladder? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>b. pancreas or liver? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>c. joints or spine? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>d. kidney? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>e. eyes, ears, or nose? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>f. mouth, throat, or jaw? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>19. <b>In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:</b></p> <p>a. high blood pressure? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>b. chest pain? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>c. headaches? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>d. paralysis? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>e. arthritis? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>f. convulsions or epilepsy? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>g. elevated cholesterol? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>h. sexually transmitted disease? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>i. cancer? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>j. diabetes or sugar in the blood or urine? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>k. stroke? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>l. Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>m. tumor, cyst, polyp, lump, or growth of any kind? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>n. mental, emotional, or behavioral disorder? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p>	<p>20. <b>In the last 10 years, has any applicant:</b></p> <p>a. had a complicated pregnancy or delivery? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>b. tested positive for antibodies to the HIV virus? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>c. been hospital confined, had surgery, or discussed surgery? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>21. <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></p> <p>a. heart or circulatory system? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>b. nervous system? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>c. digestive system? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>d. muscular or skeletal system? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>e. respiratory system? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>f. male or female reproductive system, including infertility? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>g. urinary system? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>h. thyroid, breast, or other glands? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>22. 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? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>23. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>24. 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? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>25. Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks per week? <span style="float: right;">Yes No</span>  <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).</p> <p>26. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? <span style="float: right;">Yes No</span>  <input type="checkbox"/> <input type="checkbox"/></p> <p>27. 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 below.</p>
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**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.



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

## ARIZONA 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*<sup>1</sup> (as defined below) for the last 18 months or more (not required if insured under an Arizona-domiciled organization on the date the organization was declared insolvent) with no lapse in coverage of more than 63 days.
3. My most recent coverage was under a *group health plan*<sup>2</sup> (as defined below), a governmental plan, a church plan, or an Arizona-domiciled health services organization on the date the organization was declared insolvent.
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*<sup>2</sup> (as defined below), Medicare or Medicaid.
6. I accepted and exhausted any group continuation of coverage (including COBRA) that was offered to me.

**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 \_\_\_\_\_

— OR —

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

Signature \_\_\_\_\_ Date \_\_\_\_\_

**If you signed under A, there is no need to complete the rest of this form.**

**If you signed under B, answer the questions below and complete the back 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 coverage? .....

If yes, did you maintain COBRA or group continuation until it expired? .....

YES  NO

YES  NO

### PART II PLAN DESIGN, PRICE, AND AVAILABILITY (Plan 100® full PPO \$1,000 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® Full PPO
- \$1,000 deductible male
- Single, age 55
- Standard Health Class
- Arizona Zip Code 85000

Base Rate (preferred)	\$371.00
Health Class Factor	x 1.10
	-----
Quarterly Trend Factor	\$408.10
	x 1.025
	-----
Area Factor	\$418.30
	x .95
	-----
Preexisting Waiver Factor	\$397.39
	x 1.10
	-----
Monthly Total (minimum)	\$437.13 *
	x 2.00
	-----
Monthly Total (maximum)	\$874.26 *

\* Rate is for illustration purposes only.

<sup>1</sup> *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.

<sup>2</sup> 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 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 \_\_\_\_\_  
Signature of Proposed Insured

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

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

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

I realize if I am eligible and I do not apply for a portability plan within 62 days of losing my prior coverage, this right may no longer be available to me.

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

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

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

**Option 1**

- 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. Documentation must provide proof of coverage for every three-month period of coverage. (For example, explanation of benefits for January, April, July, October, January, April...)

**Details About Your Most Recent Coverage**

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.



## MEDICAL SAVINGS ACCOUNT (MSA) AGREEMENT AND ADOPTION (only if depositing MSA money with Golden Rule).

I wish to establish an MSA with Golden Rule as custodian and direct that my contributions be deposited in my Golden Rule MSA. I adopt the current Golden Rule Custodial Agreement and agree to its terms.

I understand the following:

- 1) Golden Rule has no responsibility for the tax treatment of my MSA.
- 2) I may revoke the MSA Custodial Agreement for any reason within seven days after I receive a copy of the Custodial Agreement.
- 3) If the 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) My Golden Rule MSA will credit interest on money in my account.
- 5) Golden Rule will set up my account and begin crediting interest the later of: a) 10 days after issue of the qualified major medical; or b) the effective date of my qualified major medical.

- 6) Interest will not begin to accrue until funds are deposited with Golden Rule's agent bank.
- 7) Golden Rule or its agent bank may deduct usual administrative fees from my account and these fees may change on 60 days' prior notice.
- 8) The Custodial Agreement and Disclosure Notice are subject to change and may be changed as necessary to comply with the law.

The primary insured on the qualified Golden Rule major medical insurance will be the account holder of this MSA. If my spouse has signed this agreement, I authorize my spouse to withdraw funds from my MSA.

**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 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

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

X \_\_\_\_\_  
Signature of Spouse (if authorized to withdraw MSA Funds)

## IMPORTANT REMINDERS

### **Be sure to include the following:**

- Software printout of quote.
- Initial premium and FACT dues check.
- P.A.C. form and voided check (if paying monthly).
- Print and mail to:

### **Be sure:**

- To read the current product brochure before completing the application for insurance.
- To promptly mail the application to the above address.

**Applications received by Golden Rule more than 15 days after the signed date will not be accepted.**

## P.O. boxes are not accepted as a Primary Resident Address.

### **Note:**

- 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.
- There is no coverage until approved in writing by Golden Rule.

## IMPORTANT PORTABILITY NOTICE

All insurers are required to offer "portability plans" to eligible persons. If you are eligible, you may not be declined coverage due to your health history.

Generally, you are eligible if you:

- Have had 18 months of continuous prior health insurance coverage.
- Were most recently covered under a group health plan.\*
- Have elected and exhausted COBRA or state continuation of benefits coverage.
- Are not eligible for any other group health coverage, Medicare or Medicaid.
- Do not have other health insurance.

If you are applying for a plan with portability rights, you must write "Portability" under the Special Instructions section of this application and apply in accordance with the procedures as outlined in the "Health Insurance Portability and Accountability Act (HIPAA) of 1996 Summary and Instructions."

If you are eligible and do not apply for portability of coverage within 63 days after termination of prior coverage, you will lose your eligibility.

If you are not eligible for coverage on a guaranteed issue basis, you may still be eligible to receive credit toward the preexisting condition provision. Submit proof of creditable coverage from plans that were in force during the prior 12 months. We will advise you what portion, if any, of the preexisting condition limitation will be waived.

\* Group health plan = coverage existing in connection with employment.

