

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.	Social Security Number		Birth Date	Age	Sex	Height	Weight
Last	First								
3. 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 App.</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 App.**

**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 28 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.

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Replacing?	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)? \_\_\_\_\_
- 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
- e. Does the applicant participate in off-road biking? .....  Yes  No

**MEDICAL HISTORY -- FOR ALL APPLICANTS**

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

		Yes	No			Yes	No
14.	Is any family member (whether or not named in this application) pregnant or an expectant mother or father? .....	<input type="checkbox"/>	<input type="checkbox"/>	22.	In the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of Acquired Immune Deficiency Syndrome (AIDS)? .....	<input type="checkbox"/>	<input type="checkbox"/>
15.	Do any applicants, other than dependent children, <b>not</b> read, write, speak, and understand the English language? .....	<input type="checkbox"/>	<input type="checkbox"/>	23.	In the last 10 years, has any applicant tested positive for antibodies to the HIV virus? .....	<input type="checkbox"/>	<input type="checkbox"/>
16.	Do you have an adoption pending? .....	<input type="checkbox"/>	<input type="checkbox"/>	24.	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? .....	<input type="checkbox"/>	<input type="checkbox"/>
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? .....	<input type="checkbox"/>	<input type="checkbox"/>	25.	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"/>
18.	<b>Within the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:</b>			26.	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"/>
	a. gallbladder? .....	<input type="checkbox"/>	<input type="checkbox"/>	27.	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"/>
	b. pancreas or liver? .....	<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).		
	c. joints or spine? .....	<input type="checkbox"/>	<input type="checkbox"/>	28.	Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? .....	<input type="checkbox"/>	<input type="checkbox"/>
	d. kidney? .....	<input type="checkbox"/>	<input type="checkbox"/>	29.	Do you understand that, unless Golden Rule agrees to an earlier date, coverage for accidental injury begins on a covered person's effective date of coverage and coverage for sickness does not begin until the 15th day thereafter? .....	<input type="checkbox"/>	
	e. eyes, ears, or nose? .....	<input type="checkbox"/>	<input type="checkbox"/>	30.	Do you understand that a covered person's coverage will terminate on the date the person becomes covered under an individual plan of insurance providing indemnity or service benefits for hospital, surgical, or medical expenses? .....	<input type="checkbox"/>	
	f. mouth, throat, or jaw? .....	<input type="checkbox"/>	<input type="checkbox"/>	31.	List in "Medical History Details" any additional doctors or other health care professionals that any applicant has consulted with or been treated by in the last 5 years, and give full details on next page.		
19.	<b>In the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of:</b>						
	a. high blood pressure? .....	<input type="checkbox"/>	<input type="checkbox"/>				
	b. chest pain? .....	<input type="checkbox"/>	<input type="checkbox"/>				
	c. headaches? .....	<input type="checkbox"/>	<input type="checkbox"/>				
	d. paralysis? .....	<input type="checkbox"/>	<input type="checkbox"/>				
	e. arthritis? .....	<input type="checkbox"/>	<input type="checkbox"/>				
	f. convulsions or epilepsy? .....	<input type="checkbox"/>	<input type="checkbox"/>				
	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"/>				
20.	<b>In the last 10 years, has any applicant:</b>						
	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"/>				
21.	<b>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:</b>						
	a. heart or circulatory system? .....	<input type="checkbox"/>	<input type="checkbox"/>				
	b. nervous system? .....	<input type="checkbox"/>	<input type="checkbox"/>				
	c. digestive system? .....	<input type="checkbox"/>	<input type="checkbox"/>				
	d. muscular or skeletal system? .....	<input type="checkbox"/>	<input type="checkbox"/>				
	e. respiratory system? .....	<input type="checkbox"/>	<input type="checkbox"/>				
	f. male or female reproductive system, including infertility? .....	<input type="checkbox"/>	<input type="checkbox"/>				
	g. urinary system? .....	<input type="checkbox"/>	<input type="checkbox"/>				
	h. thyroid, breast, or other glands? .....	<input type="checkbox"/>	<input type="checkbox"/>				



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

I (we) hereby authorize 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 # \_\_\_\_\_

Bank's Name \_\_\_\_\_

Bank's Address \_\_\_\_\_

City, State, Zip \_\_\_\_\_

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

X \_\_\_\_\_  
(Signature of Payor, If not You)

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

**Attach Voided BLANK check here!**

**HEALTH INSURANCE CERTIFICATION AND AUTHORIZATION TO OBTAIN AND DISCLOSE 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.

I understand that my premium cannot be paid with an employer check unless I am certifying under (a) above, or my employer has set up a list bill account with Golden Rule.

By signing below, I certify that I understand I am applying for personal health insurance that may never be used as employer-provided insurance.

074C-799

I authorize Golden Rule to obtain information that it needs to underwrite or verify my application for insurance. Any person having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions or nonmedical information about my family or me is authorized to give it to Golden Rule. This includes information related to substance use or abuse. Any medical practitioner, medical facility, pharmacy, the Veterans Administration, the Medical Information Bureau (MIB), employer, or insurance company that may have such information is authorized to give this information to Golden Rule. Golden Rule may also release this information about my family or me to the MIB or any insurer to which I have applied for coverage.

I (we) have received notice of Golden Rule's Information Practices. This authorization shall remain valid for 30 months from the date shown below. 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 have read the above: P.A.C. Authorization, Health Insurance Certification, and Authorization to Obtain and Disclose Information.**

Signed X \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ at \_\_\_\_\_ City \_\_\_\_\_ State

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

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

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

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

Each question on the application was completed by the applicant(s). The applicant has received a Conditional Receipt or Conditions Prior to Coverage document.

I agree with the answer given for question 12b, "Will this plan replace any existing life insurance?" (If the response shown for question 12b does not reflect your understanding, please check this box and attach an explanation. )

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

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

\_\_\_\_\_  
Broker Number

**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 and Disclosure Notice.
- 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 accountholder 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 P.O. boxes are not accepted as a Primary Resident Address.**

**Be sure to include the following:**

- Software printout of quote.
- Initial premium and FACT dues check made payable to "FACT."
- 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.**

**Note:**

- Coverage is not available if:
  - any family member is currently pregnant (whether or not listed on the application); or
  - the applicant has not resided in the U.S. for the last 12 consecutive months.
- Altered applications will not be accepted.
- 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.
- 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.

