

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.			Not Required						
b.			Not Required						
c.			Not Required						
d.			Not Required						

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
MSA Deposit	+ _____ \$25 Monthly Minimum (only with MSA)

Total Monthly Payment = \$ _____ **→ If Quarterly → X3 = \$** _____
 One-Time MSA Set-Up Fee + _____ \$10 only with MSA + _____
 MSA Indemnity Rider + _____ + _____
Payment With App. = \$ _____ **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 25SM Plan Copay 35SM Plan Copay 45SM Plan Plan 100[®] Basic PlanSM MSA 100[®] Plan
 70/30 70/30 70/30 Plan 80SM MSA 80SM Plan
 50/50 50/50 50/50

Deductible: _____

- Optional Benefits: Prescription Drug Card Supplemental Accident Term Life Rider 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. Is any applicant applying for this plan as an "Eligible Individual" entitled to guaranteed coverage under Virginia state law implementing the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)? Yes No
- d. 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
- _____
- _____
- e. 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. Within the last 24 months, has the applicant had his/her license suspended or revoked? Yes No
- c. 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

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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"/>	20.	In the last 10 years, has any applicant:		
				a.	had a complicated pregnancy or delivery?	<input type="checkbox"/>	<input type="checkbox"/>
15.	Do any applicants, other than dependent children, not read, write, speak, and understand the English language?	<input type="checkbox"/>	<input type="checkbox"/>	b.	tested positive for antibodies to the HIV virus?	<input type="checkbox"/>	<input type="checkbox"/>
				c.	been hospital confined, had surgery, or discussed surgery?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Do you have an adoption pending?	<input type="checkbox"/>	<input type="checkbox"/>	21.	In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:		
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"/>	a.	heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>
				b.	nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
18.	Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:			c.	digestive system?	<input type="checkbox"/>	<input type="checkbox"/>
a.	gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>	d.	muscular or skeletal system?	<input type="checkbox"/>	<input type="checkbox"/>
b.	pancreas or liver?	<input type="checkbox"/>	<input type="checkbox"/>	e.	respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
c.	joints or spine?	<input type="checkbox"/>	<input type="checkbox"/>	f.	male or female reproductive system, including infertility?	<input type="checkbox"/>	<input type="checkbox"/>
d.	kidney?	<input type="checkbox"/>	<input type="checkbox"/>	g.	urinary system?	<input type="checkbox"/>	<input type="checkbox"/>
e.	eyes, ears, or nose?	<input type="checkbox"/>	<input type="checkbox"/>	h.	thyroid, breast, or other glands?	<input type="checkbox"/>	<input type="checkbox"/>
f.	mouth, throat, or jaw?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>
19.	In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:			23.	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"/>
a.	high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	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?	<input type="checkbox"/>	<input type="checkbox"/>
b.	chest pain?	<input type="checkbox"/>	<input type="checkbox"/>	25.	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"/>
c.	headaches?	<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).		
d.	paralysis?	<input type="checkbox"/>	<input type="checkbox"/>	26.	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"/>
e.	arthritis?	<input type="checkbox"/>	<input type="checkbox"/>	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.		
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.	Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness?	<input type="checkbox"/>	<input type="checkbox"/>				
m.	tumor, cyst, polyp, lump, or growth of any kind?	<input type="checkbox"/>	<input type="checkbox"/>				
n.	mental, emotional, or behavioral disorder? ...	<input type="checkbox"/>	<input type="checkbox"/>				

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.
VIRGINIA PORTABILITY CERTIFICATION

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

PART I Review the statements and sign where appropriate.

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

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

1. I do not have any other health insurance coverage (or it will be involuntarily terminated soon).
2. I have been insured by *creditable coverage*¹ (as defined below) for the last 18 months (12 months if an individual plan that was nonrenewed by the insurer) or more with no lapse in coverage of more than 63 days.
3. My most recent coverage was under a *group health plan*² (as defined below), a governmental plan, a church plan or an individual plan.
4. My most recent coverage was not terminated due to nonpayment of premiums, fraud, or intentional misrepresentations.
5. I am not eligible for any coverage under a *group health plan*² (as defined below), Medicare or Medicaid.
6. I accepted and exhausted any group continuation of coverage (including COBRA) that was offered to me.

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? YES NO
 Were you eligible for COBRA or group continuation coverage? YES NO
 If yes, did you maintain COBRA or group continuation until it expired? YES NO

PART II PLAN DESIGN, PRICE, AND AVAILABILITY (all actively marketed plans)

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
- Virginia Zip Code 22300

Base Rate (preferred)	\$371.00
Health Class Factor	x 1.10
	\$408.10
Quarterly Trend Factor	x 1.025
	\$418.30
Area Factor	x .89
	\$372.29
Preexisting Waiver Factor	x 1.10
Monthly Total (minimum)	\$409.52 *
	x 2.00
Monthly Total (maximum)	\$819.04 *

* Rate is for illustration purposes only.

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

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

Most Recent Employer Name and Address		Employment Termination Date		Phone No.
Most Recent Insurance Company Name and Address		Effective Date	Termination Date	ID No. Phone No.
Other Insurance Companies for the Past 18 Months		Effective Date	Termination Date	ID No. Phone No.

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

I (we) hereby authorize 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.

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

002C-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)

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 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 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.**

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

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.

IMPORTANT NOTICE

Portability:

To be an "Eligible Individual" entitled to guaranteed coverage under state law, you *must* meet all of the following qualifications: (1) you must have been continuously covered under one or more previous creditable coverage plans for at least 18 months; (2) your most recent coverage must have been under a group, individual, government, or church plan; (3) your most recent coverage must not have been terminated for fraud or nonpayment of premium; (4) you must not currently have any

other coverage; (5) you must not currently be eligible for coverage under a group plan, Medicare, or Medicaid; and (6) if you have been offered continuation coverage under COBRA or a similar state program, you must have accepted the coverage and continued the coverage for the maximum time allowed by law.

If your most recent coverage was under an individual plan and it was nonrenewed by the insurer, the time period in (1) above may be reduced to 12 months.

