

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 this application to FACT.

Member's Signature X _____ Date X _____

If you wish to apply for association group insurance, please complete the application below.

FACT ENFO 0402

**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 Name (Last, First, M.I.)			Birth Date	Age	Sex	Height	Weight
a.							
b.							
c.							
d.							
e.							

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

 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

COVERAGE INFORMATION

10. Plan: Copay 25SM Plan Copay 35SM Plan Copay 45SM Plan Plan 100[®] Basic PlanSM MSA 100[®] Plan
 80/20 of \$10,000 80/20 of \$10,000 80/20 of \$10,000 Plan 80SM MSA 80SM Plan
 70/30 of \$10,000 70/30 of \$10,000 70/30 of \$10,000
 50/50 of \$ 8,000 50/50 of \$ 8,000 50/50 of \$ 8,000

Deductible: _____ Requested Effective Date: ____/____/____

Requested Health Class: Preferred Standard Tobacco (If Question 31 is yes.)
 Primary
 Spouse

Requested PPO Option: Full PPO Network _____

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

Special Instructions: _____

BILLING (or attach health insurance illustration).

11. Monthly P.A.C. Quarterly

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

Initial Premium and FACT Dues Credit Card Authorization
 I authorize Golden Rule to bill my VISA/MASTERCARD account for full initial Premium and FACT dues. **If quarterly billing requested, full initial premium will be for three months.** Visa MasterCard Exp. Date ____/____/____

 X _____
 Signature of credit cardholder

Total Quarterly Payment
 X3 = \$ _____
 One-Time MSA Set-Up Fee + _____
 MSA Indemnity Rider + _____
Payment With Application = \$ _____

OTHER COVERAGE

12. 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

13. Will the term life benefit replace any existing **life** insurance? Company Name _____ Policy # _____ Yes No

14. 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: _____

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

Any person who, knowingly and with the intent to defraud any insurance company or other person, files an application for insurance or settlement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto, commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

DRIVING

16. 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? If yes, provide details in "Medical History Details." 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 |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 17. Is any family member (whether or not named in this application) pregnant or an expectant mother or father? | <input type="checkbox"/> | <input type="checkbox"/> | 24. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the: | | |
| 18. 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"/> |
| 19. Do you have an adoption pending? | <input type="checkbox"/> | <input type="checkbox"/> | b. nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. 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"/> |
| 21. 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"/> | 25. In the last 10 years, has any applicant had any diagnosis or treatment by a physician for Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. mouth, throat, or jaw? | <input type="checkbox"/> | <input type="checkbox"/> | 26. 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"/> |
| 22. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of: | | | 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | 28. 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"/> | 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 30. 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"/> | 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 10.) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. convulsions or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> | 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. | | |
| 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"/> | | | |
| 23. In the last 10 years, has any applicant: | | | | | |
| a. had a complicated pregnancy or delivery? | <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"/> | | | |

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 # _____

X _____
(Signature of Payor, If not You)

Bank's Name _____

Bank's Address _____

City, State, Zip _____

Draft On _____
Day

X _____ **Attach Voided BLANK check here!**
(Date Signed)

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.

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.

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 person, employer,

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insurance company, consumer reporting agency, or the Medical Information Bureau (MIB) having nonmedical information about 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: P.A.C. Authorization, Health Insurance Certification, and Authorization to Obtain and Disclose Information.

Signed X _____ / _____ / _____ at _____ City _____ State _____
Date

X _____
Signature of Primary Applicant (You)

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

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, 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.

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 notice of Golden Rule's 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.

I have read the above: Authorization to Obtain and Disclose Health Information.

Signed X _____ / _____ / _____ at _____ City _____ State _____
Date

X _____
Signature of Primary Applicant (You)

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

X _____
Signature of Spouse (if to be covered)

