FACT MEMBERSHIP ENROLLMENT FORM (If not already a member). MARYLAND

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 ____________________

FACT ENFO 0402 **If you wish to apply for association group insurance, please complete the application below.**

GOLDEN RULE INSURANCE COMPANY
LAWRENCEVILLE, IL 62439
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)			❑ M ❑ S						
2. Spouse									

3. Dependent Children Name: Last	First	M.I.		Birth Date	Age	Sex	Height	Weight
a.			Not Required					
b.								
c.								
d.								

4. Primary Resident Address: ____________________
Street City State Zip

5. Phone Numbers: (   ) ____________________ (   ) ____________________ Best times to call ____________
Daytime Evening

6. Payor (If not You): ____________________
Name Street City State Zip

7. Your Beneficiary: ____________________ You will be the beneficiary for your spouse.
Name Relationship Age

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 $99,999 ❑ $100,000 or more

BILLING (or attach health insurance illustration).

10. ❑ Monthly P.A.C. ❑ Quarterly

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**	= $ ________	**Total Quarterly Payment**
One-Time MSA Set-Up Fee	+ ________	$10 only with MSA		+ ________	One-Time MSA Set-Up Fee
MSA Indemnity Rider	+ ________			+ ________	MSA Indemnity Rider
Payment With Application	= $ ________	Make check payable to "FACT."		= $ ________	**Payment With Application**

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

Primary Applicant's Initials __________ Spouse's Initials __________ Date ____/____/____

COVERAGE INFORMATION

10. Plan:

- ❑ Copay 25℠ Plan
  - ❑ 80/20 of $10,000
  - ❑ 70/30 of $10,000
  - ❑ 50/50 of $ 8,000
- ❑ Copay 35℠ Plan
  - ❑ 80/20 of $10,000
  - ❑ 70/30 of $10,000
  - ❑ 50/50 of $ 8,000
- ❑ Copay 45℠ Plan
  - ❑ 80/20 of $10,000
  - ❑ 70/30 of $10,000
  - ❑ 50/50 of $ 8,000
- ❑ Plan 100®
- ❑ Plan 80℠
- ❑ Basic Plan℠
- ❑ MSA 100® Plan
- ❑ MSA 80℠ Plan

Deductible: ______________ Requested Effective Date: ______/ ______/ ______

Requested Health Class:

	Preferred	Standard	Tobacco (If Question 26 is yes.)
Primary	❑	❑	❑
Spouse	❑	❑	❑

Optional Benefits:
- ❑ Prescription Drug Card
- ❑ Supplemental Accident
- ❑ Term Life
- ❑ MSA Indemnity Benefit

Requested PPO Option: ❑ Full PPO

Special Instructions: ____

____

____

____

____

OTHER COVERAGE

	Yes	No
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, 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

	Yes	No
b. Will this plan replace any existing **life** insurance? Company Name ______________________ Policy #______________	❑	❑
c. In the last 7 years, 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? If yes, who? ______________________ Policy/Certificate # ______________________	❑	❑

DRIVING

	Yes	No
13. In the last 24 months, has any applicant participated in driving any type of motorcycle? If yes, please answer the following questions:	❑	❑
a. Name of applicant(s)? ______________________________		
b. Does the applicant have a valid motorcycle license?	❑	❑
c. Within the last 24 months, has the applicant had his/her license suspended or revoked?	❑	❑
d. Within the last 24 months, has the applicant, while operating a motor vehicle, been involved in an accident or received a moving violation?	❑	❑

Primary Applicant's Initials ______________ Spouse's Initials ______________ Date_____/_____/_____

MEDICAL HISTORY -- FOR ALL APPLICANTS

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

	Yes	No
14. Is any family member (whether or not named in this application) pregnant or an expectant mother or father?	❑	❑
15. Do any applicants, other than dependent children, **not** read, write, speak, and understand the English language?	❑	❑
16. Do you have an adoption pending?	❑	❑
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?	❑	❑
18. **Within the last 7 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?	❑	❑
19. **In the last 7 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. Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness?	❑	❑
m. tumor, cyst, polyp, lump, or growth of any kind?	❑	❑
n. mental, emotional, or behavioral disorder?	❑	❑
20. **In the last 7 years, has any applicant:**		
a. had a complicated pregnancy or delivery?	❑	❑
b. tested positive for antibodies to the HIV virus?	❑	❑
c. been hospital confined, had surgery, or discussed surgery?	❑	❑
21. **In the last 7 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?	❑	❑
22. In the last 7 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?	❑	❑
23. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more?	❑	❑
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?	❑	❑
25. 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).	❑	❑
26. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months?	❑	❑

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.

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.

Primary Applicant's Initials _______________ Spouse's Initials _______________ Date _____/_____/_____

MEDICAL HISTORY DETAILS -- FOR ALL APPLICANTS -- Continued

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

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 before signing below.

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 to the best of my knowledge and belief. **I UNDERSTAND AND AGREE** that: **(1)** this application and the payment of the initial premium do not give me immediate coverage; **(2)** with respect to health coverage, unless Golden Rule agrees to an earlier date, coverage for illness begins on the 15th day after a person becomes insured for injury; **(3)** with respect to health coverage, there will be no benefits for any loss incurred in the first year of coverage due to a pre-existing condition; **(4) incorrect or incomplete information on this application may result in loss 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 existing coverage to be replaced for 90 days beyond the Golden Rule effective date will void this coverage.** I have received a Conditional Receipt or Conditions Prior to Coverage.

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)

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

MARYLAND 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 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, or a church 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 -- or -- I was not offered group continuation of coverage (including COBRA).

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 ______________

If you signed under A, go to page 7.

— OR —

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

Signature ______________________________ Date ______________

If you signed under B, answer the questions below and complete the rest 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?.. ❑YES ❑NO
If yes, did you maintain COBRA or group continuation until it expired? .... ❑YES ❑NO

PART II PLAN DESIGN, PRICE, AND AVAILABILITY (Plan 100®, Full PPO, $1,000 deductible, or *Copay 25*)

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
- Maryland Zip Code 20600

Base Rate (preferred)	$425.00
Health Class Factor	x 1.10
	$467.50
Quarterly Trend Factor	x 1.05
	$490.88
Area Factor	x .78
	$382.88
Preexisting Waiver Factor	x 1.10
Monthly Total (minimum)	$421.17 *
	x 2.00
Monthly Total (maximum)	$842.34 *

* 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 and the business owner's spouse 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 ______________________________ X ______________________________
Signature of Proposed Insured 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 group coverage, this right may no longer be available to me.

X ______________________________ X ______________________________
Signature of Proposed Insured 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.

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 # ____________________

X ____________________
(Signature of Payor, If not You)

Financial Institution's Name ____________________

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.

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 person, employer, 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 ____________________
Date 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)

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.

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 ____________________
Date 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:

- Health Insurance Illustration.
- Initial premium and FACT dues check made payable to "FACT."
- P.A.C. form and voided check (if paying monthly).
- 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:

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

764C-0403
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