

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, 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. 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)
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 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 15SM Plan Copay 25SM Plan Copay 35SM Plan Plan 100[®] Basic PlanSM MSA 100[®] Plan
 80/20 of \$5,000 80/20 of \$5,000 80/20 of \$10,000 Plan 80SM MSA 80SM Plan
 50/50 of \$3,000 50/50 of \$3,000 50/50 of \$ 6,000
 50/50 of \$5,000 50/50 of \$5,000 50/50 of \$10,000

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 Network: _____

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)? _____
- 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

Notice: The state of Ohio requires that we provide you with the following information: Any person who, with intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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:		
15.	Do any applicants, other than dependent children, not read, write, speak, and understand the English language?	<input type="checkbox"/>	<input type="checkbox"/>	a.	had a complicated pregnancy or delivery?	<input type="checkbox"/>	<input type="checkbox"/>
16.	Do you have an adoption pending?	<input type="checkbox"/>	<input type="checkbox"/>	b.	tested positive for antibodies to the HIV virus?	<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"/>	c.	been hospital confined, had surgery, or discussed surgery?	<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:			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:		
a.	gallbladder?	<input type="checkbox"/>	<input type="checkbox"/>	a.	heart or circulatory system?	<input type="checkbox"/>	<input type="checkbox"/>
b.	pancreas or liver?	<input type="checkbox"/>	<input type="checkbox"/>	b.	nervous system?	<input type="checkbox"/>	<input type="checkbox"/>
c.	joints or spine?	<input type="checkbox"/>	<input type="checkbox"/>	c.	digestive system?	<input type="checkbox"/>	<input type="checkbox"/>
d.	kidney?	<input type="checkbox"/>	<input type="checkbox"/>	d.	muscular or skeletal system?	<input type="checkbox"/>	<input type="checkbox"/>
e.	eyes, ears, or nose?	<input type="checkbox"/>	<input type="checkbox"/>	e.	respiratory system?	<input type="checkbox"/>	<input type="checkbox"/>
f.	mouth, throat, or jaw?	<input type="checkbox"/>	<input type="checkbox"/>	f.	male or female reproductive system, including infertility?	<input type="checkbox"/>	<input type="checkbox"/>
19.	In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:			g.	urinary system?	<input type="checkbox"/>	<input type="checkbox"/>
a.	high blood pressure?	<input type="checkbox"/>	<input type="checkbox"/>	h.	thyroid, breast, or other glands?	<input type="checkbox"/>	<input type="checkbox"/>
b.	chest pain?	<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"/>
c.	headaches?	<input type="checkbox"/>	<input type="checkbox"/>	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"/>
d.	paralysis?	<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"/>
e.	arthritis?	<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"/>
f.	convulsions or epilepsy?	<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).		
g.	elevated cholesterol?	<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"/>
h.	sexually transmitted disease?	<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.		
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.

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.

