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)	❑ M ❑ S						
2.	Spouse							

3. Dependent Children Name (Last, First, M.I.)		Birth Date	Age	Sex	Height	Weight
a.	Not Required					
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
- ❑ $15,001 to $35,000
- ❑ $35,001 to $50,000
- ❑ $50,001 to $75,000
- ❑ $75,001 to $99,999
- ❑ $100,000 or more

10. Primary Applicant's Mother's Maiden Name: (Last Name Only)

Spouse's Mother's Maiden Name: (Last Name Only)

THIS PLAN IS ISSUED ON AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN.

Primary Applicant's initials Spouse's initials Date / /

COVERAGE INFORMATION

11. **Requested Effective Date:** __ __/__ __/__ __ __ __ **Requested Health Class:** Primary: ❑ Preferred ❑ Standard ❑ Tobacco (if question 31 is yes)
Plan includes Preferred Network; if not wanted, check here ❑ Spouse: ❑ Preferred ❑ Standard ❑ Tobacco (if question 31 is yes)
Network Name: ______________________________

Copay Plans

❑ Copay 25

Deductible
- ❑ $ 500
- ❑ $ 750
- ❑ $1,250

Optional
- ❑ Term Life Benefit
- ❑ Supplemental Accident

HSA Plans

❑ HSA 100℠

Deductible Single	Deductible Family
❑ $1,050	❑ $2,100
❑ $1,800	❑ $3,650
❑ $2,700	❑ $5,450

Optional
- ❑ Term Life Benefit
- ❑ Hospital Indemnity Rider (Not Available with $1,050 or $2,100 deductible)

High Deductible

- ❑ Plan 100®
- ❑ Plan 80℠
- ❑ Basic Plan℠

Deductible
- ❑ $ 500 (*Basic Plan* only)
- ❑ $1,000
- ❑ $1,500
- ❑ $2,500
- ❑ $5,000

Optional
- ❑ Term Life Benefit
- ❑ Supplemental Accident
- ❑ Prescription Drug Card (Not Available with *Basic Plan*)

BILLING (or attach health insurance illustration)

12. **Initial Payment With Application**
- ❑ Check
- ❑ Credit Card

Ongoing Payments
- ❑ Monthly P.A.C.
- ❑ Quarterly Direct Bill →

Initial Payment Credit Card Authorization

I authorize Golden Rule to bill my Visa/MasterCard account for the Initial Payment. **If quarterly billing requested, the Initial Payment will be for three months plus any one-time costs.**

Type of Card: ❑ MasterCard ❑ Visa Expiration Date: Month ____ Year ____

Security Code ____ (last 3 digits in signature line)

Name as Printed on Card ______________________________

Billing Address ______ City ______ State ______ ZIP ______

Card Number ______________________________

X______________________________
Signature of Authorized User

Base Premium Amount	$_______				
Term Life Benefit	+_______	Optional			
Supplemental Accident	+_______	Optional			
Prescription Drug Card	+_______	Optional			
HSA Deposit (*HSA 100* only)	+_______	$25 Minimum			
Total Monthly Payment	= $_______	→ **If Quarterly** →	**X3** = $_______	**Total Quarterly Payment**	
One-Time HSA Set-Up Fee	+_______	$10 only with HSA	+_______	One-Time HSA Set-Up Fee	
One-Time HSA Indemnity Rider	+_______		+_______	One-Time HSA Indemnity Rider	
Initial Payment	= $_______	Make check payable to "Golden Rule."	= $_______	**Initial Payment**	

OTHER COVERAGE

13. 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

14. Will the term life benefit replace any existing **life** insurance? Company Name ______________ Policy #__________ Yes ❑ No ❑

15. 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.) . . . . ❑ ❑
Person: ______ Company: ______ Action Taken: ______
Date: ______ Reason for Action: ______

16. Has any applicant previously applied for, or been covered by, Golden Rule? . . . . ❑ ❑
If yes, who? ______________________ Policy/Certificate # ______________________

Primary Applicant's initials __________ Spouse's initials __________ Date ___/___/___

DRIVING

		Yes	No
17.	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? If yes, provide details in "Medical History Details."	❑	❑

MEDICAL HISTORY -- FOR ALL APPLICANTS

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

		Yes	No
18.	Is any family member (whether or not named in this application) pregnant or an expectant mother or father?	❑	❑
19.	Do any applicants, other than dependent children, **not** read, write, speak, and understand the English language?	❑	❑
20.	Do you have an adoption pending?	❑	❑
21.	**In the last 6 months**, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind?	❑	❑
22.	**Within the last 10 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?	❑	❑
23.	**In the last 10 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 (excluding AIDS or HIV)?	❑	❑
	i. cancer?	❑	❑
	j. diabetes or sugar in the blood or urine?	❑	❑
	k. stroke?	❑	❑
	l. tumor, cyst, polyp, lump, or growth of any kind?	❑	❑
	m. mental, emotional, or behavioral disorder?	❑	❑
24.	**In the last 10 years, has any applicant:**		
	a. had a complicated pregnancy or delivery?	❑	❑
	b. been hospital confined, had surgery, or discussed surgery?	❑	❑
25.	**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. 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?	❑	❑
26.	In the last 10 years, has any applicant had, been diagnosed as having, or been treated for, Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness?	❑	❑
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?	❑	❑
28.	In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more?	❑	❑
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 conviction or driver's license suspension?	❑	❑
30.	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).	❑	❑
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 11.	❑	❑
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.		

Primary Applicant's initials ____________ Spouse's initials ____________ Date ___/___/___

MEDICAL HISTORY DETAILS -- FOR ALL APPLICANTS

Question Number	Person	Symptoms or Conditions	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 and read the section below carefully before signing.

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)** unless Golden Rule agrees to an earlier date, coverage for illness begins on the 15th day after a person becomes insured for injury; **(3)** 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 voidance 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 other coverage existing on the Golden Rule effective date for more than 90 days after the Golden Rule effective date will void this coverage.** I have received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

Signed X ______/______/______ at ______________________________
Date City State

X ______________________________
Signature of Primary Applicant (You)

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

X ______________________________
Signature of Spouse (if to be covered)

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 No.______________________________

Financial Institution's Name____________________________

Address____________________________________

City, State, ZIP ______________________________

Draft On ______________________________
Day

X ______________________________
(Signature of Account Holder)

X ________________
(Date Signed)

Include Voided BLANK check!

HEALTH INSURANCE CERTIFICATION AND AUTHORIZATION TO OBTAIN AND DISCLOSE NONMEDICAL 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) no portion of the premium is paid, either directly or indirectly, by my employer; and

(b) neither myself nor my employer treats this plan as employer-provided health insurance.

If you cannot certify to **both** (a) and (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.

120D-0405

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 Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical 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). I have collected the initial premium and given the Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

X ______________________________

Signature of Licensed Broker

Broker Number

I agree with the answer given for Question 14, "Will the term life benefit replace any existing **life** insurance?" (If the response shown for Question 14 does not reflect your understanding, please check this box and attach an explanation. ❑)

X ______________________________

Print Full Name

HEALTH SAVINGS ACCOUNT (HSA) AGREEMENT AND ADOPTION (only if depositing HSA money with Golden Rule)

I wish to establish an HSA with Golden Rule as custodian. This HSA will be exclusively for the purpose of paying or reimbursing qualified medical expenses of me, my spouse, and dependents.

I represent that I am eligible to contribute to this HSA. Specifically, I:

1) am covered by (or have applied for) a Golden Rule high deductible health plan (HDHP);
2) am not also covered by any other health plan that is not an HDHP (except for permitted insurance or coverage allowed by law);
3) am not enrolled in Medicare; and
4) cannot be claimed as a dependent on another person's tax return.

I adopt the current Golden Rule HSA Custodial Agreement and agree to its terms. I understand the following:

1) Golden Rule has no responsibility for the tax treatment of my HSA.
2) I may revoke the HSA Custodial Agreement for any reason within seven days after I receive a copy of the HSA Custodial Agreement.
3) If the HSA 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) Golden Rule will set up my HSA and begin crediting interest the later of: a) 10 days after issue of the HDHP; or b) the effective date of my HDHP.
5) Interest will not begin to accrue until funds are deposited with Golden Rule's agent bank.
6) The HSA Custodial Agreement and Disclosure Statement is subject to change and may be changed as necessary to comply with the law.

If my spouse has also signed this agreement, I authorize my spouse to withdraw funds from my HSA.

Required Certification: Under penalties of perjury, I certify that (1) my Social Security number below is correct; and (2) I am not subject to backup 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

Primary Applicant's
Social Security Number __ __ __ – __ __ – __ __ __ __

X ______________________________

Signature of Primary Applicant

X ______________________________

Signature of Spouse (if authorized to withdraw HSA funds)

If your spouse is not applying for an HDHP but is authorized to withdraw HSA Funds:

Spouse's Printed Name ______________________________

Spouse's Social Security Number __ __ __ – __ __ – __ __ __ __

Spouse's Date of Birth______________________________

REVIEW BEFORE MAILING THE APPLICATION

Be sure:

- To read the current product brochure before completing the application for insurance.

Note:

- If you were previously insured by UnitedHealthcare, you must still fully complete this application accurately. Our underwriters do not have access to UnitedHealthcare underwriting and claims files.
- 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.
- **P.O. Boxes are not accepted as a Primary Resident Address.**
- **Applications received by Golden Rule more than 15 days after the signed date will not be accepted.**

Mail the Application and Related Forms Packet to the address below.

Be sure to include the following:

- Health Insurance Illustration.
- Initial premium check made payable to "Golden Rule."
- P.A.C. authorization and voided check (if paying monthly).
- Complete replacement notice (1055) if applicant has had other coverage in the last 30 days.

Mail to: Golden Rule Insurance Company
HEALTH APPLICATION
Golden Rule Building
7440 Woodland Drive
Indianapolis, Indiana 46278-1719

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