

**FACT MEMBERSHIP ENROLLMENT FORM**

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 the Golden Rule Insurance Company Application for Insurance to FACT.

Member's Signature X \_\_\_\_\_ Date X \_\_\_\_\_

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

FACT ENFO 0105

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

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

Street (Include Apt.) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

5. Phone Numbers: ( ) ( )

Home Other Best number and time to call E-mail Address \_\_\_\_\_

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: \_\_\_\_\_ 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

10. Primary Applicant's Mother's Maiden Name: \_\_\_\_\_ Spouse's Mother's Maiden Name: \_\_\_\_\_

(Last Name Only) (Last Name Only)



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

**COVERAGE INFORMATION**

11. Requested Health Class: Primary:  Preferred  Stand. I  Stand. II  
 Spouse:  Preferred  Stand. I  Stand. II  
 Tobacco Use: Primary  Yes  No Spouse  Yes  No Child a.  Yes  No Child b.  Yes  No Child c.  Yes  No Child d.  Yes  No Child e.  Yes  No

Requested Effective Date: \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Plan includes Preferred Network; if not wanted, check here   
 Network: \_\_\_\_\_  
 Special Instructions: \_\_\_\_\_

(See Question 31 for applicants age 18 and older, including dependent children)

<b>Copay Plans</b>	<input type="checkbox"/> Copay Plus <sup>SM</sup>	<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<b>HSA Plans</b>	<input type="checkbox"/> HSA 100 <sup>®</sup>	Single <input type="checkbox"/> \$1,100 <input type="checkbox"/> \$1,850 <input type="checkbox"/> \$2,850 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000	Family <input type="checkbox"/> \$ 2,200 <input type="checkbox"/> \$ 3,800 <input type="checkbox"/> \$ 5,650 <input type="checkbox"/> \$ 7,500 <input type="checkbox"/> \$10,000	<b>Plan 80, Plan 100, and Saver 80</b>	<input type="checkbox"/> Saver 80 <sup>SM</sup>	<input type="checkbox"/> \$ 500 (Saver 80 only) <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000
	<input type="checkbox"/> Copay Saver <sup>SM</sup>	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000		<input type="checkbox"/> HSA Saver <sup>®</sup>					
<b>Optional</b>	<input type="checkbox"/> Term Life Benefit	<input type="checkbox"/> Maternity	<b>Optional</b>	<input type="checkbox"/> Term Life Benefit	<input type="checkbox"/> Preventive Care	<input type="checkbox"/> Hospital Indemnity Rider	<b>Optional</b>	<input type="checkbox"/> Term Life Benefit	<input type="checkbox"/> Maternity
	<input type="checkbox"/> Supplemental Accident	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000		<input type="checkbox"/> Preventive Care	<input type="checkbox"/> Hospital Indemnity Rider	(Not Available with \$1,100 or \$2,200 deductible)		<input type="checkbox"/> Supplemental Accident	<input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000
	<input type="checkbox"/> 2 Additional Dr. Visits a Year (Copay Saver only)	<input type="checkbox"/> Lifetime Maximum-\$5 Million		<input type="checkbox"/> Lifetime Maximum-\$5 Million				<input type="checkbox"/> Lifetime Maximum-\$5 Million	

**BILLING (or attach a health quote printout.)**

12. Initial Payment With Application:  Check  EFT (with online app. only)  Credit Card  
 Ongoing Payments:  Monthly (EFT)  List Bill (include forms)  Quarterly Direct Bill

FACT Dues	\$	3.00	
Base Premium Amount	+		
Term Life Benefit	+		Optional
Maternity Benefit	+		Optional
Supplemental Accident	+		Optional
Preventive Care	+		Optional
2 Additional Dr. Visits a Year	+		Optional
Prescription Drug Card	+		Optional
Lifetime Maximum-\$5 Million	+		Optional
HSA Deposit	+		\$25 Monthly Minimum (only with HSA)
Child Admin. Fee	+		\$5 per month (only if primary applicant <18 yrs)
<b>Total Monthly Payment</b>	= \$		<b>If Quarterly</b> → <b>X3</b> = \$ <b>Total Quarterly Payment</b>
One-Time HSA Set-Up Fee	+		\$10 only with HSA
One-Time HSA Indemnity Rider	+		
<b>Initial Payment</b>	= \$		Make check payable to "FACT" = \$ <b>Initial Payment</b> ←

**Initial Payment Credit Card Authorization**  
 I authorize FACT 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: \_\_\_\_\_  
 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

**OTHER COVERAGE**

13. Within the last 63 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.) Yes  No   
 Person: \_\_\_\_\_ Company: \_\_\_\_\_ Action Taken: \_\_\_\_\_  
 Date: \_\_\_\_\_ Reason for Action: \_\_\_\_\_

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

**DRIVING -- FOR ALL APPLICANTS**

17. 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. Which applicant(s)?  Primary  Spouse  Child a.  Child b.  Child c.  Child d.  Child e.
- b. Does applicant have a valid motorcycle license?  Yes  Yes  Yes  Yes  Yes  Yes  Yes
- 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

**MEDICAL HISTORY -- FOR ALL APPLICANTS**

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

- |   | Yes                      | No                       |   | Yes                      | No                       |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 18. Is any family member (whether or not named in this application) pregnant or an expectant mother or father? .....                                      | <input type="checkbox"/> | <input type="checkbox"/> | 25. <b>In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:</b>  |                          |                          |
| 19. Do any applicants, other than dependent children, <b>not</b> 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"/> |
| 20. Do you have an adoption pending? .....  | <input type="checkbox"/> | <input type="checkbox"/> | b. nervous system? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. <b>In the last 6 months</b> , 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"/> |
| 22. <b>Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:</b>    |                          |                          | 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"/> | 26. Has any applicant: (a) tested positive for exposure to the HIV infection; (b) been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) caused by HIV infection; or (c) been diagnosed as having any other sickness or condition derived from an HIV infection? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| f. mouth, throat, or jaw? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 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"/> |
| 23. <b>In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:</b>                                       |                          |                          | 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"/> |
| a. high blood pressure? .....   | <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"/> |
| b. chest pain? .....  | <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"/> |
| 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"/> | 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.) .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. arthritis? .....   | <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.  |                          |                          |
| 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. 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"/> |   |                          |                          |
| 24. <b>In the last 10 years, has any applicant:</b>   |                          |                          |   |                          |                          |
| a. had a complicated pregnancy or delivery? .....   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| b. been hospital confined, had surgery, or discussed surgery? .....   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |





# FLORIDA CERTIFICATION

Review the statements and sign where appropriate.

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*<sup>1</sup> (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*<sup>2</sup> (as defined below), a governmental plan, or a church plan; or under an individual plan that terminated due to: the insurer's insolvency; the insurer's discontinuance of all its individual coverage in Florida; or the fact that I no longer live in a Florida service area of my prior insurer's network 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 conversion plan, a *group health plan*<sup>2</sup> (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 under A. or B.

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 \_\_\_\_\_

<sup>1</sup>*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.

<sup>2</sup>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.

879C-0904

## THIRD PARTY NOTIFICATION IN CASE OF NONPAYMENT OF PREMIUMS

Under Florida law, you may have the right to designate a secondary addressee to receive an additional notice from Golden Rule regarding life insurance coverage that is about to lapse due to nonpayment of premium when you are 64 or older. You have this right if you: (a) have chosen life insurance coverage to be delivered in Florida; and (b) are not choosing to pay your premiums by monthly preauthorized check (P.A.C.).

If you qualify, please choose one of the following options:

### Protection Against Unintended Lapse

- I understand that I have the right to designate one person other than myself to receive notice of cancellation of life insurance coverage for nonpayment of premium when I am 64 or older. **I elect NOT** to designate any person to receive such notice.
- I would like the following person notified in case of nonpayment of premium when I am 64 or older.

Full Name of Person to Be Notified \_\_\_\_\_

Home Address \_\_\_\_\_

City \_\_\_\_\_

State \_\_\_\_\_

ZIP Code \_\_\_\_\_

Applicant's Signature \_\_\_\_\_

Date \_\_\_\_\_

33038-0600

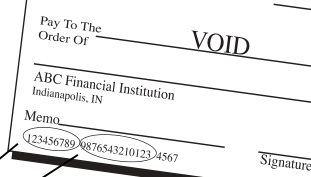
**ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION -- ONLY IF PAYING BY EFT**

I (we) hereby authorize FACT 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 of its termination from me.

Nine-digit Check Routing No. \_\_\_\_\_

Checking Account No. \_\_\_\_\_



Financial Institution's Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Draft On \_\_\_\_\_ (Date Signed)

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date; or 2) up to 10 days after the due date.

Account Holder's Signature X \_\_\_\_\_

E-mail Address \_\_\_\_\_

**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) 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.

953B-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 employer, insurance company, government agency, consumer-reporting agency,

or the Medical Information Bureau (MIB) having information about my occupation(s), avocations, driving history, criminal history, or prior insurance coverage for 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 \_\_\_\_\_ 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 \_\_\_\_\_ 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)

**HEALTH SAVINGS ACCOUNT (HSA) APPLICATION (only if opening an HSA with Exante)**

By signing below, I acknowledge that:

- I wish to establish an HSA with Exante Bank as custodian.
- I understand and agree that my HSA will be opened under and governed by Exante Bank's Custodial and Deposit Agreement. Terms of this Agreement will be binding on me unless I close my account within 30 days. This document will be sent to me when my account is opened, along with Exante Bank's Privacy Policy and Schedule of Fees and Charges.
- I authorize Exante Bank to provide information about my HSA, including my account number, to Golden Rule, and those acting on behalf of Golden Rule or Exante Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that Golden Rule and all others acting on behalf of Golden Rule (if applicable), may provide information on my behalf to establish and maintain my HSA.
- I understand my monthly account statements will be made available to me electronically. I agree to notify Exante Bank if I wish to have statements mailed to my home address.
- If I have filled out the information to request an additional debit card, I hereby request Exante Bank to issue a debit card on my account to the person indicated and I acknowledge I will be liable for the use of the debit card by the Authorized User.
- I authorize Exante to share information about my HSA with the authorized user named and to allow withdrawals by check, debit card, or other means to be made by such authorized user.
- I certify that the information provided in this application is true and complete.

**Per the USA Patriot Act:** To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

Have you, within the last 6 months, been covered under another health insurance plan? .....  Yes  No  
 Has your spouse? .....  Yes  No

<b>REQUEST FOR AN AUTHORIZED USER DEBIT CARD (OPTIONAL)</b>	
Authorized User's _____	_____
First Name	Middle Initial
Authorized User's _____	_____
Last Name	
Authorized User's _____	_____
Date of Birth	
Authorized User's _____	_____
Social Security No.	

X \_\_\_\_\_  
 Signature of Primary Applicant  
 Primary Applicant's  
 Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

155X-0806

**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 quote.
  - Initial payment check made payable to "FACT"
  - EFT authorization and voided check (if paying via EFT).
- Mail to:** Golden Rule Insurance Company  
 HEALTH APPLICATION  
 PO Box 68994  
 Indianapolis, Indiana 46268-0994