

**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<br><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 times 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  
Prior Employment (If within 2 years): Household Income: \$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 Effective Date: \_\_\_/\_\_\_/\_\_\_\_\_ Special Instructions: \_\_\_\_\_  
 All plans include a preferred network; if not wanted, check here  Network Name: \_\_\_\_\_  
**Requested Health Class:** Primary:  Preferred  Standard I  Standard II  
 Spouse:  Preferred  Standard I  Standard II  
**Tobacco Use:** **Primary** **Spouse** **Child a.** **Child b.** **Child c.** **Child d.** **Child e.** (See question 32 for applicants age 18 and older, including dependent children).  
 Yes  Yes  Yes  Yes  Yes  Yes  Yes

**AVAILABLE PRODUCTS**

**HIGH DEDUCTIBLE PLANS**  
 Plan 100<sup>®</sup>  \$ 500 (Saver 80 only)  
 Plan 80<sup>SM</sup>  \$1,000 (Saver 80 only)  
 Saver 80<sup>SM</sup>  \$1,500  \$2,500  \$3,500  
 \$5,000

**COPAY PLANS**  
 Copay Select<sup>SM</sup>  \$ 500 (Copay Select only)  
 \$1,000 (Copay Select only)  
 Copay Saver<sup>SM</sup>  \$1,500  \$2,500  \$5,000

**HSA PLANS**

|   | Single<br>2008   | Family<br>2008   |
|---|--|--|
| <input type="checkbox"/> HSA 100 <sup>®</sup>   | <input type="checkbox"/> \$1,100<br><input type="checkbox"/> \$1,900<br><input type="checkbox"/> \$2,900 | <input type="checkbox"/> \$2,200<br><input type="checkbox"/> \$3,850<br><input type="checkbox"/> \$5,800 |
| <input type="checkbox"/> HSA Saver <sup>®</sup> | <input type="checkbox"/> \$3,500<br><input type="checkbox"/> \$5,000                                     | <input type="checkbox"/> \$7,500<br><input type="checkbox"/> \$10,000                                    |

**OPTIONAL BENEFITS**  
 Term Life Benefit  
 Lifetime Maximum - \$5 Million  
 Maternity (Not available with HSA Plans)  
 Supplemental Accident (Not available with HSA Plans):  
 \$500  \$1,000  
 Preventive Care (Not available with Copay Select)  
 2 Additional Dr. Visits a Year (Copay Saver only)  
 Prescription Drug - no annual max. (Copay Select only)  
 Prescription Drug Card (Plan 100 and Plan 80 only)  
 HSA Hospital Indemnity Rider (Not available with \$1,100 or \$2,200 deductibles)

**BILLING (or attach health insurance quote)**

12. **Initial Payment With Application:**  Check  EFT  Credit Card  
**Ongoing Payments:**  Monthly (EFT)  Quarterly Direct Bill  
 FACT Dues \$ 3.00  
 Base Premium Amount + \_\_\_\_\_  
 Term Life Benefit + \_\_\_\_\_ Optional  
 Lifetime Maximum-\$5 Million + \_\_\_\_\_ Optional  
 Maternity Benefit + \_\_\_\_\_ Optional  
 Supplemental Accident + \_\_\_\_\_ Optional  
 Preventive Care + \_\_\_\_\_ Optional  
 2 Additional Dr. Visits a Year + \_\_\_\_\_ Optional  
 Prescription Drug-no annual max. + \_\_\_\_\_ Optional  
 Prescription Drug Card + \_\_\_\_\_ Optional  
 HSA Deposit + \_\_\_\_\_ \$25 Monthly Minimum  
 (only with HSA)  
 Child(ren) Admin. Fee + \_\_\_\_\_ \$5 Monthly  
 (only if primary applicant <18 yrs)

**Total Monthly Payment** = \$ \_\_\_\_\_  
 One-Time HSA Set-Up Fee + \_\_\_\_\_ \$10 (only with HSA)  
 One-Time HSA Indemnity Rider + \_\_\_\_\_ Optional (only with HSA)  
**Initial Payment** = \$ \_\_\_\_\_ Make check payable to "FACT."  
**If Quarterly, Total Monthly Payment x 3** = \$ \_\_\_\_\_  
 One-Time HSA Set-Up Fee + \_\_\_\_\_ \$10 (only with HSA)  
 One-Time HSA Indemnity Rider + \_\_\_\_\_ Optional (only with HSA)  
**Initial Payment** = \$ \_\_\_\_\_ Make check payable to "FACT."

**IMPORTANT: Premium will be verified and may be adjusted up or down during the underwriting process.**

**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.) 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  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

**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. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:   |                          |                          |
| 19. 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"/> |
| 20. Do you have an adoption pending? .....  | <input type="checkbox"/> | <input type="checkbox"/> | b. nervous system? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? ..... | <input type="checkbox"/> | <input type="checkbox"/> | c. digestive system? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. 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"/> | 26. In the last 10 years, has any applicant had any diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS)? .....   | <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 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"/> |
| 23. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:                                      |                          |                          | 28. 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"/> | 29. 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"/> | 30. 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"/> | 31. 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"/> | 32. 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"/> |
| f. convulsions or epilepsy? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 33. 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"/> |   |                          |                          |
| 24. In the last 10 years, has any applicant:  |                          |                          |   |                          |                          |
| 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"/> |   |                          |                          |





