Please Print in Blue Ink.

APPLICATION FOR SHORT TERM PREFERRED PROVIDER MEDICAL INSURANCE
GOLDEN RULE INSURANCE COMPANY -- LAWRENCEVILLE, ILLINOIS 62439

PROPOSED INSURED _____ (First / Middle Initial / Last) _____ (Birth Date)* _____ (Age) ☐ Male ☐ Female (Sex)

RESIDENT ADDRESS
PO Boxes are not accepted.

_____ (Street / City / State / ZIP) _____ (Telephone No.)

1. List below any dependents to be covered under the policy.

Dependent's Name (Last, First, M.I.)	Relationship to You	Date of Birth*
	Spouse	/ /
		/ /
		/ /
		/ /
		/ /
		/ /

*If born within 30 days prior to the effective date of coverage, the person will not be covered under the policy.

		Yes	No
2.	Are you or is any family member (whether or not named in this application) an expectant mother or father? **If yes, coverage cannot be issued.**	☐	☐
3.	Have you or has anyone named above been declined for insurance due to health reasons? If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy.)	☐	☐
4.	Have you or has any person named in Question 1 lived in the 50 states of the USA or the District of Columbia for **less than** the past 12 months? If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy.)	☐	☐
5.	Do you or does any person named in Question 1 now have hospital or medical expense insurance that **will not** terminate prior to the requested effective date? If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy.)	☐	☐
6.	Within the last 5 years, have you or has anyone listed on the application received medical or surgical consultation, advice, or treatment, including medication, for **any of the following:** liver disorders, kidney disorders, emphysema, diabetes, cancer, heart or circulatory system disorders (including high blood pressure), alcohol or drug abuse or immune system disorders, including HIV infection, or tested positive for HIV infection? If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy.)	☐	☐

DEDUCTIBLE: ☐ $ 500 ☐ $1,000 ☐ $1,500 ☐ $2,500

REQUESTED EFFECTIVE DATE: ____/____/____
(See Statement of Understanding section below.)

MONTHS OF COVERAGE: ☐ 1 MO. ☐ 2 MO. ☐ 3 MO. ☐ 4 MO. ☐ 5 MO. ☐ 6 MO.

STATEMENT OF UNDERSTANDING

I have read this application and represent that the information shown on it is true and complete. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule with this application; (b) no benefits will be paid for a health condition that existed within the last 5 years prior to the date insurance takes effect; and (c) if coverage is issued, the coverage will not be a continuation of any prior coverage. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy that may be issued. I understand that for an application sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after receipt by Golden Rule. I understand that for a mailed application, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after the **postmark date** affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (i) the requested effective date; or (ii) the date received by Golden Rule. I understand that the broker is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

X _____ Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child

X _____ State where you signed this application

X _____ Date you signed and read application

_____ Licensed Agent or Broker (Please Print.)

_____ Individual Producer #

Important Note:
"Postmark date" means the date of the postmark as affixed by the U.S. Postal Service.

No application will be accepted if received by Golden Rule more than 15 days after the date signed.

ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

PAYMENT OPTIONS: SINGLE OR MONTHLY (Initial Payment Method Required With Application)

Electronic Funds Transfer (EFT) and Credit Card payments will be collected on the date we issue coverage, or the effective date of the policy, whichever is later.
If Initial Payment is EFT, Ongoing Payment must be EFT.

If you choose Check as your Initial Payment Method, please mail your check with your completed application - checks are deposited upon receipt.

☐ **Single Payment** (one single payment for all months of coverage chosen/lump sum):

- ☐ **EFT $ Amount** _____ Includes $20 refundable application fee.
  For this method of payment, you must complete the EFT Authorization below.
- ☐ **Credit card $ Amount** _____ (Total Single Payment. Includes $20 refundable application fee.)
  For this method of payment, you must complete the Credit Card Authorization below.
- ☐ **Check or money order $ Amount** _____ Includes $20 refundable application fee.
  For this method of payment, you must make check or money order payable to Golden Rule Insurance Company.

OR

☐ **Monthly Payment:**

Initial Payment ☐ EFT ☐ Credit Card ☐ Check or money order (For this method of payment, you must make check or money order payable to Golden Rule Insurance Company.)

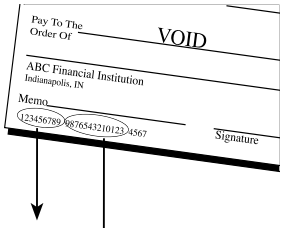
$ Amount _____ First month amount (shown) includes a one-time $20 refundable application fee.

Ongoing Payments (Choose one)

- ☐ **Electronic Funds Transfer** (EFT) (No billing fee.)
  Additional monthly EFT payments will not include the $20 application fee.
- ☐ **Credit Card** (No billing fee.)
  Additional monthly Credit Card payments will not include the $20 application fee.

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION — COMPLETE ONLY IF PAYING BY EFT

I (we) hereby authorize Golden Rule to initiate debit entries to the account indicated below.
I also authorize the named financial institution 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.



Type of Account: ☐ Checking ☐ Savings

Nine-digit Routing No. _____

Account No. _____

Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____ (Day) _____/_____/_____ (Date Signed)

X _____
Authorized Account Signature

Email Address _____

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.

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CREDIT CARD AUTHORIZATION — COMPLETE ONLY IF PAYING BY CREDIT CARD

Credit Card Authorization ☐ Visa ☐ MasterCard ☐ American Express

I authorize Golden Rule Insurance Company to bill my Visa/MasterCard/American Express account for the total payment.

Account No. | Expiration Date | Billing ZIP Code | X Signature of Authorized User

NOTE: Some card issuers/financial institutions charge cash advance fees on insurance payments.

Charge On _____
Day

Only select a charge date between the 1st and 28th of the month.

PAYOR INFORMATION (If other than Proposed Insured)

Payor: Name | Email Address

Street | City | State | ZIP

ADDITIONAL ADDRESS INFORMATION (Complete if Mailing Address is different than Resident Address listed on page 1.)

Mailing Address

Street (Include Apt.)

City | State | ZIP

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