

**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 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 (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: \_\_\_\_\_ You will be the beneficiary for your spouse.

Name Relationship Age

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

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

(Last Name Only) (Last Name Only)

**COVERAGE INFORMATION**

11. Requested Effective Date: \_\_\_/\_\_\_/\_\_\_ Requested Health Class: Primary:  Preferred  Standard  Tobacco (if question 32 is yes)  
 Plan includes Preferred Network; if not wanted, check here  Spouse:  Preferred  Standard  Tobacco (if question 32 is yes)  
 Network Name: \_\_\_\_\_ Special Instructions: \_\_\_\_\_

<b>Copay Plans</b>	<input type="checkbox"/> Copay Select <sup>SM</sup>	<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500	<b>HSA Plans</b>	Single	Family	<b>Optional High Deductible</b>	<input type="checkbox"/> \$ 500 (Saver 80 only) <input type="checkbox"/> \$1,000 (Saver 80 only) <input type="checkbox"/> \$1,500 (Saver 80 only) <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"/> HSA 100 <sup>®</sup> <input type="checkbox"/> HSA Saver <sup>®</sup>	<input type="checkbox"/> \$1,050 <input type="checkbox"/> \$1,800 <input type="checkbox"/> \$2,700 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000		<input type="checkbox"/> \$ 2,100 <input type="checkbox"/> \$ 3,650 <input type="checkbox"/> \$ 5,450 <input type="checkbox"/> \$ 7,500 <input type="checkbox"/> \$10,000
<b>Optional</b>	<input type="checkbox"/> Preventive Care <small>(Not Available with Copay Select)</small>		<b>Optional</b>	<input type="checkbox"/> Preventive Care		<b>Optional</b>	<input type="checkbox"/> Preventive Care
	<input type="checkbox"/> Supplemental Accident			<input type="checkbox"/> Hospital Indemnity Rider			<input type="checkbox"/> Supplemental Accident
	<input type="checkbox"/> Mental Disorder Benefit			<input type="checkbox"/> Mental Disorder Benefit			<input type="checkbox"/> Mental Disorder Benefit

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

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

Base Premium Amount \$ \_\_\_\_\_  
 Preventive Care + \_\_\_\_\_ Optional  
 Supplemental Accident + \_\_\_\_\_ Optional  
 Prescription Drug Card + \_\_\_\_\_ Optional  
 Mental Disorder Benefit + \_\_\_\_\_ Optional  
 HSA Deposit + \_\_\_\_\_ \$25 Monthly Min. (only with HSA)  
**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** ←

**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: \_\_\_\_\_  
 Security Code \_\_\_\_\_ (last 3 digits in signature line) Month \_\_\_\_\_ Year \_\_\_\_\_  
 Name as Printed on Card \_\_\_\_\_  
 Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_  
 Card Number \_\_\_\_\_  
 X \_\_\_\_\_  
 Signature of Authorized User

**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 (6) 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  **N/A**

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**

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. 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? 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 known 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 known 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. In the last 10 years, has any applicant had any signs, symptoms, diagnosis, or treatment of any 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 tested positive for antibodies to the HIV virus? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. <b>In the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of:</b>                                    |                          |                          | 28. In the last 10 years, has any applicant had any known 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. <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"/> |   |                          |                          |



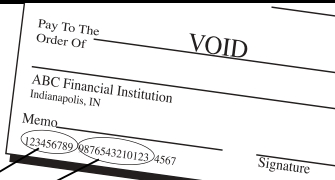
**MONTHLY P.A.C. AUTHORIZATION -- ONLY IF PAYING BY MONTHLY P.A.C.**

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 of its termination from me.

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

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



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

Address \_\_\_\_\_

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

Draft On \_\_\_\_\_

Day (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 \_\_\_\_\_

**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.

I understand that my premium cannot be paid with an employer check unless I am certifying under (a) above, or my employer has set up a list bill account with Golden Rule.

By signing below, I certify that I understand I am applying for personal health insurance that may never be used as employer-provided insurance.

074C-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 Monthly P.A.C. Authorization and the Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.**

Signed X \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ at \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Date

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 have read the above: Authorization to Obtain and Disclose Health Information.**

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.

Signed X \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ at \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_  
Date

X \_\_\_\_\_  
Signature of Primary Applicant (You)

X \_\_\_\_\_  
Signature of Parent/Guardian (if You are a minor)

X \_\_\_\_\_  
Signature of Spouse (if to be covered)

