APPLICATION FOR SHORT TERM MEDICAL INSURANCE
GOLDEN RULE INSURANCE COMPANY
INDIANAPOLIS, INDIANA 46278-1719

Please Print In Black Ink

Applicant(s) Information

Gender	Name (Last, First, M.I.)	Birth Date*	MUST BE ACCURATE** Height	Weight
☐ Male ☐ Female	Primary (You)			
☐ Male ☐ Female	Spouse			
☐ Male ☐ Female	Child 1			
☐ Male ☐ Female	Child 2			
☐ Male ☐ Female	Child 3			
☐ Male ☐ Female	Child 4			
☐ Male ☐ Female	Child 5			

* If born within 30 days prior to the effective date of coverage, the person will not be covered under the policy/certificate.
** Applicants must meet our height and weight guidelines to qualify for coverage.
If you need to list additional dependents, please use lined paper, sign and date it, and check this box. ☐

Resident Physical Address (where you live and pay taxes). PO Boxes are not accepted.

Street (Include Apt.)	City	State	ZIP Code

Mailing Address (if different than Resident Address)

Street (Include Apt.)	City	State	ZIP Code

Payor (if not you)

Name (Last, First, M.I.)	Relationship to Primary		
	☐ Relative ☐ Other (Specify): ________		
Street (Include Apt.)	City	State	ZIP Code

Contact Information

	Phone Number	Email
Primary (You)		
Spouse		
Payor (if not You)		

Plan Selection

Requested Effective Date: _____/_____/_____ *(See Statement of Understanding section)*	Days of Coverage: _____________

Plans *(Choose one plan and one coinsurance option for that plan)*	☐ Short Term Medical Value Select A	☐ 70/30 - $5,000 ☐ 70/30 - $10,000 ☐ 60/40 - $5,000 ☐ 60/40 - $10,000
	☐ Short Term Medical Value Select	☐ 70/30 - $5,000 ☐ 70/30 - $10,000 ☐ 60/40 - $5,000 ☐ 60/40 - $10,000
	☐ Short Term Medical Copay Select A	80/20 - $5,000
	☐ Short Term Medical Copay Select	80/20 - $5,000
	☐ Short Term Medical Plus Select A	☐ 80/20 - $2,000 ☐ 80/20 - $5,000 ☐ 80/20 - $10,000 ☐ 60/40 - $2,000 ☐ 60/40 - $5,000 ☐ 60/40 - $10,000
	☐ Short Term Medical Plus Select	☐ 80/20 - $2,000 ☐ 80/20 - $5,000 ☐ 80/20 - $10,000 ☐ 60/40 - $2,000 ☐ 60/40 - $5,000 ☐ 60/40 - $10,000
	☐ Short Term Medical Plus Elite A	100/0 - $0
	☐ Short Term Medical Plus Elite	100/0 - $0
Deductible Amount *(Choose one)*	☐ $1,000 (*Not Available with Short Term Medical Plus Elite A or Short Term Medical Plus Elite)* ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $12,500	

Optional Benefits Selection

Supplemental Accident Benefit *(You may only choose one)*	☐ $1,000 (*Not Available with Short Term Medical Plus Elite A or Short Term Medical Plus Elite)* ☐ $2,500 ☐ $5,000 ☐ $10,000 ☐ $12,500

Application Questions

General Information		Yes	No
G1	Has any applicant been declined for insurance due to health reasons? If yes, select each person: ☐ Primary ☐ Spouse ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Child 4 ☐ Child 5 The person(s) named will not be covered under the policy/certificate.	☐	☐
G2	Has any applicant lived in the 50 states of the USA or the District of Columbia for **less than** the past 12 months? If yes, select each person: ☐ Primary ☐ Spouse ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Child 4 ☐ Child 5 The person(s) named will not be covered under the policy/certificate.	☐	☐

Medical History Information		Yes	No
M1	Are you or is any family member (whether or not named in this application) an expectant mother or father, in the process of adopting a child, or undergoing infertility treatment? **If yes, coverage cannot be issued.**	☐	☐
M2	Within the last 5 years, has any applicant received medical or surgical consultation, advice, or treatment, including medication, for **any of the following:** blood disorders, liver disorders, kidney disorders, chronic obstructive pulmonary disorder (COPD) or emphysema, diabetes, cancer, multiple sclerosis, heart or circulatory system disorders (excluding high blood pressure), Crohn's disease or ulcerative colitis, or alcohol or drug abuse or immune system disorders (excluding HIV and AIDS)? If yes, select each person: ☐ Primary ☐ Spouse ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Child 4 ☐ Child 5 The person(s) named will not be covered under the policy/certificate.	☐	☐
M3	Has any applicant had testing performed, other than HIV testing, and has not received results, or been advised by a medical professional to have treatment, testing, or surgery that has not been performed? If yes, select each person: ☐ Primary ☐ Spouse ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Child 4 ☐ Child 5 The person(s) named will not be covered under the policy/certificate.	☐	☐
M4	Within the last 5 years, has any applicant received a diagnosis or treatment for HIV infection from a doctor or other licensed clinical professional, or had a positive test for HIV infection performed by a doctor or other licensed clinical professional (excluding an initial positive result that further testing showed to be false)? If yes, select each person: ☐ Primary ☐ Spouse ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Child 4 ☐ Child 5 The person(s) named will not be covered under the policy/certificate.	☐	☐

Application Questions *(continued)*

Other Coverage Information		Yes	No
O1	Does any applicant now have hospital or medical expense insurance that **will not** terminate prior to the requested effective date? If yes, select each person: ☐ Primary ☐ Spouse ☐ Child 1 ☐ Child 2 ☐ Child 3 ☐ Child 4 ☐ Child 5 The person(s) named will not be covered under the policy/certificate.	☐	☐

THIS IS NOT QUALIFYING HEALTH COVERAGE ("MINIMUM ESSENTIAL COVERAGE") THAT SATISFIES THE HEALTH COVERAGE REQUIREMENT OF THE AFFORDABLE CARE ACT. IF YOU DO NOT HAVE MINIMUM ESSENTIAL COVERAGE, YOU MAY OWE AN ADDITIONAL PAYMENT WITH YOUR TAXES.

Statement of Understanding

I have read this application and represent that the information on it is true and complete. I understand that:

(1) No insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule with this application.

(2) No benefits will be paid for a health condition that exists prior to the date insurance takes effect.

(3) If coverage is issued, the coverage will not be a continuation of any prior coverage.

(4) Unless Golden Rule agrees to an earlier date, coverage for illness begins on the 6th day after a person becomes insured for injury.

(5) Incorrect or incomplete information in this application may result in voidance of coverage and claim denial.

(6) The information provided in this application, and any supplement or amendments to it, will be made a part of any policy/certificate that may be issued.

(7) For an application sent by any electronic means, insurance, if approved, will be effective the later of:

- (a) The requested effective date; or
- (b) The day after receipt by Golden Rule.

(8) For a mailed application, insurance, if approved, will be effective the later of:

- (a) The requested effective date; or
- (b) 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 day received by Golden Rule

(9) The producer is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

Signature Information

	Signature	Date Signed
Proposed Insured (or Parent/Legal Guardian if proposed Insured is a child)		

Important Notes:

- "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.
- The state of Ohio requires that we provide you with the following information. Any person who, with the intent to defraud or knowing that he is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

Read and fill out the following FACT Member ship Enrollment Form

FACT Membership Enrollment Form *(continued)*

I hereby enroll for Basic ($4 a month) membership in the FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS (FACT). Upon completion of this enrollment form and payment of initial dues, I understand that: (a) I will be entitled to FACT's benefits; (b) these benefits may change from time to time; (c) some benefits may have a delayed effective date; (d) my membership will become effective on the day this enrollment form is dated and signed; (e) I am eligible to apply for association group insurance; and (f) I authorize the release of my name, address, date of birth, certificate and phone numbers, application date, membership level, and email address listed on the Golden Rule Application for Short Term Medical Insurance to FACT. Note: Accident Insurance is included in your FACT membership and you will have an opportunity to name your beneficiary(ies) by mail or on the FACT website.

X ______________________________ Member's Signature

X ______________________________ Date

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

FACT ENFO STM 0216

PAYMENT OPTIONS: Single or Monthly (Initial Payment Method Required With Application)

Electronic Funds Transfer (EFT) and Credit Card payment will be collected at the time of application. If coverage is not issued, we will refund the money we collected, minus the nonrefundable application fee.

☐ **Single Payment** (one single payment for all days of coverage chosen):

- ☐ **EFT $ Amount** _________ Includes $20 nonrefundable application fee.
  Please complete the EFT Authorization below.
- ☐ **Credit Card $ Amount** _________ Includes $20 nonrefundable application fee.
  Please complete the Credit Card Authorization below.
- ☐ **Check or money order $ Amount** _________ Includes $20 nonrefundable application fee.
  Please mail your check or money order, payable to Golden Rule Insurance Company, with your application. Checks are deposited upon receipt.

OR

☐ **Monthly Payment**: (Based on 30 days of coverage.) Final Premium Payment may be less due to less than 30 days of coverage remaining.

Initial Payment ☐ EFT (Ongoing payment must be EFT.) ☐ Credit Card ☐ Check or money order
Please mail your check or money order, payable to Golden Rule Insurance Company, with your application. Checks are deposited upon receipt.

$ Amount _________ Initial Payment amount (shown) includes a one-time $20 nonrefundable application fee.

Ongoing Payments (Choose one)

- ☐ **Electronic Funds Transfer** (EFT)
  Ongoing monthly EFT payments will not include the $20 application fee
- ☐ **Credit Card**
  Ongoing monthly Credit Card payments will not include the $20 application fee

Producer

X ______________________________ Print Full Name

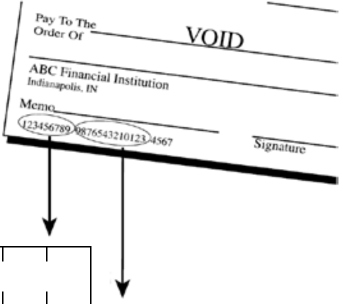
Producer Number

Electronic Funds Transfer Authorization – Complete Only If Paying By EFT

I (we) hereby authorize FACT or 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

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.

Credit Card Authorization – Complete Only If Paying By Credit Card

Credit Card Authorization ☐ Visa ☐ MasterCard ☐ American Express

I authorize FACT or Golden Rule Insurance Company to charge my Visa/MasterCard/American Express Account for the Single Payment or Monthly Payment above.

| | | | | | | | | | | | | | | | |
Account No.

_____/__________
Expiration Date (Mth/Yr)

| | | | | |
Billing ZIP Code

X ____________________________
Signature of Authorized User

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

Charge On ___________ (29th, 30th, 31st not available)
Day

Disclosure

If your requested effective date is in 2018:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your certificate carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your certificate might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage. Also, this coverage is not "minimum essential coverage." If you don't have minimum essential coverage for any month in 2018, you may have to make a payment when you file your tax return unless you qualify for an exemption from the requirement that you have health coverage for that month.

If your requested effective date is in 2019:

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your certificate carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your certificate might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

CONSENT TO RECEIVE ELECTRONIC RECORDS AND TO CONDUCT TRANSACTIONS ELECTRONICALLY

By submitting this consent form or a health insurance application or HMO enrollment form, you hereby consent to presentation, delivery, storage retrieval and transmission of "Communications" related to "Our Transaction" as electronic records instead of in paper form.

For the purposes of this form, "Our Transaction" means the entirety of the business relationship between you and us. "Communications" includes, but is not limited to:

1. Your application or enrollment form, including subsequent amendments;
2. Information related to Our Transaction that we are required to provide or make available in writing such as privacy notices or fraud warnings;
3. Documents related to Our Transaction such as policy, certificate, or evidence of coverage forms, claim forms, explanation of benefit forms, premium notices, or other administrative forms (to the extent permitted by applicable law);
4. Any emails, faxes, recorded telephone calls, or other electronic transmissions of information between you and us and an insurance producer contracted with us, or between us and any third party.

Subject to our obligations to protect your privacy, we may, at our sole discretion, post Communications on a website (in which case they will be sent or received, as the case may be, regardless of whether or not we own, operate or control the website). Or send them in or attached to an email. Please be advised that communication by unencrypted email presents a risk of disclosure to, or interception by, unintended third parties. You must promptly tell us about any change to your electronic or physical mailing address, or other contact information.

You acknowledge that you can receive or access Communications because you have the following:

- A telephone
- A computer and printer
- A device or computer program for listening to audio CDs, mp3, WAV or other common computer audio files
- An Internet browser
- Access to the Internet
- A valid email address
- Adobe Acrobat Reader or other sufficient PDF reader

You can request a free copy of any Communications, or withdraw your consent to receive electronic Communications at any time by sending a written request to:

Policy Administration
PO Box 31372
Salt Lake City, UT 84131-0372

☐ I hereby consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. All of the Communications between the time you submit your consent and withdraw your consent will remain valid and binding on both you and us notwithstanding your withdrawal.

☐ I hereby DO NOT consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. If you do not consent, we will conduct all future business with you in paper form.

X ______________________________
Primary Applicant *(You)*

X ______________________________
Parent/Guardian *(if you are a minor)* Relationship

____
Primary Applicant *(You)* Email Address

X ______________________________
Parent/Guardian *(if you are a minor)* Email Address

____
Date

____
Policy ID Number

44177a-X-0518