

Application Instructions

Just print/fill out the application by hand as best you can. On any dates for health history, you only need a month/year and do not need the exact date.

Please fax it to us Toll Free at (877) 718-8056 using this cover page or if you prefer, you may scan/email it back to your agent using his/her email address. Your agent will call you shortly after the application arrives.

Please DO NOT mail the application to the address on the forms.

Enter Your Agents' name: _____

Add Accident: \$5,000 _____ \$7,500 _____ \$10,000 _____

Add Critical Illness: \$5,000 _____ \$10,000 _____ or higher \$ _____

Add Dental/Vision: Dental _____ Vision _____

Add Life Insurance: Face Amount? _____

You only need to fax or scan/email the application back to us. We do not need the original.

If you have any questions or need help in any way, please call us Toll Free at (866) 270-6209 and ask for your agent.



Golden Rule Insurance Company

Application Packet

Have you:

- ✓ Signed all forms necessary for health insurance application?
- ✓ Answered all applicable questions?
- ✓ Selected a method of payment?

UnitedHealthOne is a brand representing a portfolio of insurance products offered to individuals and families through the UnitedHealthcare family of companies. Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter and administrator of these plans.

892D-G-1110

FACT Membership Enrollment Form

Texas

I hereby enroll for Basic \$4 Choice \$20 Elite \$40 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 Insurance Company Application for 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.

Member's Signature X _____ Date X _____

FACT ENFO 1110

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

These health insurance plans are issued as association group plans and available only to members of FACT, Federation of American Consumers and Travelers.

What is FACT?

FACT is an independent consumer association whose members benefit from the "pooling" of resources. Benefits range from medical savings to consumer service discounts. If you're not already a member, you are required to join FACT.

SUBMITTING YOUR COMPLETED APPLICATION

- Review your application to be sure it is completed.
- Sign and date your application and related forms.
Signature is also required for your spouse if your spouse is to be covered.
- **Applications received by Golden Rule more than 15 days after the signed date will not be accepted.**
- **Mail the Application and Related Forms and be sure to include the following:**
 - Health insurance quote.
 - Initial payment:
 - Check made payable to "FACT";
 - EFT authorization (if paying via EFT); or
 - Credit card authorization (if paying via credit card).

Please Note:

- You will be notified of the actions taken within 45 days after the date of application, or be given the reason for delay.
- There is no coverage until approved in writing by Golden Rule.

**GOLDEN RULE INSURANCE COMPANY
APPLICATION FOR INSURANCE**

MUST BE COMPLETED BY THE APPLICANT(S)

PLEASE PRINT IN BLACK INK

APPLICANT(S) INFORMATION

1. REASON FOR APPLICATION: New Application Add a dependent ID Number Reinstatement Change deductible (for additions, reinstatements, or deductible changes)

2. PRIMARY APPLICANT'S INFORMATION:

a. Name (Last, First, M.I.): _____

b. Mailing Address
Street (Include Apt.)
City State ZIP

c. A physical address is required if different than your mailing address. P.O. Boxes are not accepted as a physical address.

Physical Address
Street (Include Apt.)
City State ZIP

d. Phone Numbers: () () Best number and times to call Email Address
Home Other

e. Payor: (If not You): Name Email Address
Street City State ZIP

f. Your Beneficiary: Name Relationship Age You will be the beneficiary for your spouse.

g. Your Occupation: h. Marital Status: Married Single

3. APPLICANTS FOR COVERAGE: Please list only those persons needing coverage.

Gender	Name (Last, First, M.I.)	Social Security No.	Birth Date	Age	Full-time Student	MUST BE ACCURATE	
						Height	Weight
<input type="checkbox"/> Male <input type="checkbox"/> Female	a. Primary (You)						
<input type="checkbox"/> Male <input type="checkbox"/> Female	b. Spouse						
<input type="checkbox"/> Male <input type="checkbox"/> Female	c. Child						
<input type="checkbox"/> Male <input type="checkbox"/> Female	d. Child						
<input type="checkbox"/> Male <input type="checkbox"/> Female	e. Child	NOT REQUIRED					
<input type="checkbox"/> Male <input type="checkbox"/> Female	f. Child						
<input type="checkbox"/> Male <input type="checkbox"/> Female	g. Child						

If you need to list additional dependents, please use lined paper, sign and date it, and check this box.
*A full-time student is one who is enrolled in and attending an accredited college or university on a full-time basis.



4. Do all applicants, other than dependent children, read, write, speak, and understand the English language? Yes No

COVERAGE INFORMATION — Must complete for all new applications.

5. Requested Effective Date: ___/___/_____

Unless we agree to an earlier date, the effective date will be the later of: (a) the requested effective date, or (b) 30 days after the application is received by Golden Rule. Both injuries and illnesses will have the same effective date.

6. All plans include a preferred network. Network Name: _____

7. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, indicate who below.) Yes No

a. Primary **b. Spouse** **c. Child** **d. Child** **e. Child** **f. Child** **g. Child**
 Yes Yes Yes Yes Yes Yes Yes

8. Requested Health Class: Primary: Preferred I Preferred II Standard I Standard II
 Spouse: Preferred I Preferred II Standard I Standard II

9. For additions and reinstatements, complete only if changing the deductible for all insureds.

PRODUCT SELECTION & BILLING (or attach a health insurance quote)

Copay SelectSM

\$1,000 \$1,500 \$2,500 \$3,500
 \$5,000 \$7,500 \$10,000

Coinsurance —
 Out-of-Pocket Maximum After Deductible
 0%
 80/20 — \$3,000
 70/30 — \$5,000

Plan 100[®]

Plan 80SM

Saver 80SM

\$1,000 (Saver 80 only)
 \$1,500 \$2,500 \$5,000
 \$7,500 \$10,000

HSA 100[®]

HSA 70SM

\$1,250 (Single Only)
 \$2,500 (Single and Family)
 \$3,000 (Single Only)
 \$3,500 (Single Only)
 \$5,000 (Single and Family)
 \$6,000 (Family Only)
 \$7,000 (Family Only)
 \$10,000 (Family Only)

FACT Membership Dues (Basic \$4, Choice \$20, Elite \$40):

\$ _____

Base Premium Amount

+ _____

OPTIONAL BENEFITS — See current brochure for availability

\$25 Office Visit Copay

+ _____ Optional

4-Dr. Office Visit Copay

- _____ Optional

Prescription Drug — \$200 Deductible

+ _____ Optional

Prescription Drug — Copay Card

+ _____ Optional

Prescription Drug — Discount Card Only

- _____ Optional

Supplemental Accident:

\$500 \$1,000 \$2,500 \$5,000 \$10,000

+ _____ Optional

Term Life: Primary \$50,000 \$100,000 \$150,000

+ _____ Optional

Term Life: Spouse \$50,000 \$100,000 \$150,000

+ _____ Optional

Accidental Death: Primary

+ _____ Optional

Accidental Death: Spouse

+ _____ Optional

UnitedHealthcare Vision

+ _____ Optional

HSA Deposit

+ _____ \$25 Monthly Min.

Total Monthly Payment

= \$ _____

One-Time HSA Set-Up Fee

+ _____ \$10

Initial Monthly Payment (Payable to "FACT")

= \$ _____

If Quarterly, Total Monthly Payment x 3

= \$ _____

One-Time HSA Set-Up Fee

+ _____ \$10

Initial Quarterly Payment (Payable to "FACT")

= \$ _____

10. Initial Payment With Application: Check EFT Credit Card

Ongoing Payments: Monthly EFT (no billing fee) Direct Bill (\$10 monthly billing fee) List Bill (include forms; \$25 monthly admin. fee per list bill group)
 Quarterly Direct Bill (\$10 quarterly billing fee)

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

Feb 22 2011 12:20:35

PREVIOUS OR CURRENT HEALTH INSURANCE COVERAGE (Completing this section may make you eligible for an earlier effective date for illnesses.)

11. Within the last 63 days, has any applicant **been covered** by any type of **medical** insurance? Yes No
 If yes, complete chart below. Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced.

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Is this to be replaced?	Termination Date

12. Will the term life benefit replace any existing **life** insurance? Yes No
 Company Name _____ Policy Number _____
13. Has any applicant ever had an application or policy voided, declined, rated, 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: _____
14. Has any applicant previously applied for, or been covered by, Golden Rule or UnitedHealthcare? Yes No
 Name _____ Policy/Certificate Number _____

DRIVING — FOR ALL APPLICANTS

15. 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)? a. Primary b. Spouse c. Child d. Child e. Child f. Child g. Child
 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 any motor vehicle license suspended or revoked? Yes No
 d. Within the last 24 months, has the applicant, while operating any 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! YOU MUST PROVIDE DETAILS OF EACH YES ANSWER IN THE "MEDICAL HISTORY DETAILS" SECTION.

16. Are you, or is any family member (whether or not named in this application), pregnant or an expectant mother or father, or in the process of surrogate pregnancy, or do you or any family member have an adoption pending? Yes No
17. In the last 5 years, has any applicant filed a claim and/or received benefits from disability insurance or Worker's Compensation? Yes No
18. Has any applicant had or been advised to have: (a) any testing (other than routine testing, such as pap or mammogram); or (b) any treatment, which has not yet been completed? Yes No
19. In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind? Yes No
20. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more? Yes No
21. In the last 5 years, has any applicant used an illegal drug; had any diagnosis or treatment of an alcohol or drug dependency, problem, or abuse; been advised to reduce alcohol intake; or had any alcohol- or drug-related moving violation, arrest, or driver's license suspension? Yes No
22. Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks* per week? Yes No
 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, or 1 oz. of hard liquor).

MEDICAL HISTORY — FOR ALL APPLICANTS (continued)

23. In the last 10 years, has any applicant:
- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| a. Had a complicated pregnancy or delivery (including a caesarean section)? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Consulted a health-care provider for any condition or symptom(s) for which a diagnosis has not been established? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Had, been diagnosed as having, or been treated for, Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness, or tested positive for antibodies to the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had any abnormal physical exam, X-ray, EKG, MRI, CT scan, or any adverse or abnormal laboratory or other test results? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been confined in a hospital for anything other than childbirth? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Had placement, treatment, or maintenance of an internal or external implant or prosthetic device? | <input type="checkbox"/> | <input type="checkbox"/> |

In the last 10 years, has any applicant had testing or additional tests recommended for, or had any signs, symptoms, diagnosis, or treatment of, any disease, disorder, or abnormality of any of the following:

- | | | | |
|---|----------------------|---|----------------------|
| <p>24. Digestive System</p> <p>a. gallbladder, pancreas, or liver?</p> <p>b. ulcers?</p> <p>c. gastroesophageal reflux disease (acid reflux, GERD)?</p> <p>d. rectal bleeding?</p> <p>e. other digestive system disorder or condition?</p> <p>25. Urinary System</p> <p>a. kidney?</p> <p>b. other urinary system disorder or condition?</p> <p>26. Eyes, Ears, Nose</p> <p>a. ear or sinus infections (more than two in the past 12 months)?</p> <p>b. other disorder or condition of the eyes, ears, or nose?</p> <p>27. Mouth, Throat, or Jaw</p> <p>28. Skin Disorders</p> <p>29. Heart or Circulatory System</p> <p>a. chest pain?</p> <p>b. high or low blood pressure?</p> <p>c. elevated cholesterol?</p> <p>d. stroke?</p> <p>e. shunts, stents, or pacemaker?</p> <p>f. other heart or circulatory system disorder or condition?</p> <p>30. Male or Female Reproductive System</p> <p>a. infertility or erectile dysfunction?</p> <p>b. sexually transmitted disease?</p> <p>c. abnormal mammogram or Pap smear?</p> <p>d. other male or female reproductive system disorder or condition?</p> | <p>Yes</p> <p>No</p> | <p>31. Blood, Gland, Endocrine, or Metabolic</p> <p>a. thyroid, breast, or other glands?</p> <p>b. diabetes or sugar in the blood or urine?</p> <p>c. anemia?</p> <p>d. immune system disorder (other than AIDS or HIV)?</p> <p>e. other blood, endocrine, or metabolic disorder or condition?</p> <p>32. Brain and Nervous System</p> <p>a. migraines or chronic or severe headaches?</p> <p>b. seizures or epilepsy?</p> <p>c. mental, emotional, or behavioral disorder (including anorexia or bulimia)?</p> <p>d. multiple sclerosis or paralysis?</p> <p>e. other brain or nervous system disorder or condition?</p> <p>33. Muscular or Skeletal System</p> <p>a. joints, bones, spine, or back?</p> <p>b. arthritis or fibromyalgia?</p> <p>c. amputation?</p> <p>d. other muscular/skeletal system disorder or condition?</p> <p>34. Respiratory System</p> <p>a. asthma or allergies?</p> <p>b. sleep apnea?</p> <p>c. other respiratory system disorder or condition?</p> <p>35. Cancer, Cyst, or Tumor</p> <p>a. cancer?</p> <p>b. tumor, cyst, polyp, lump, or growth of any kind?</p> <p>36. Birth Defects or Congenital Abnormalities</p> <p>a. Down's syndrome?</p> <p>b. cerebral palsy?</p> <p>c. other birth defect or congenital abnormality?</p> | <p>Yes</p> <p>No</p> |
|---|----------------------|---|----------------------|
37. In the last 5 years, has any applicant had any signs, symptoms, diagnosis, or treatment for any other disease, disorder, injury, or condition (excluding childbirth) that is not listed on this application?
- | | |
|--------------------------|--------------------------|
| Yes | No |
| <input type="checkbox"/> | <input type="checkbox"/> |

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.

MEDICAL HISTORY DETAILS — FOR ALL APPLICANTS

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

If you need more space to provide complete and accurate information, please use lined paper, sign and date it, and check this box.

BROKER STATEMENT: Review the completed application before signing below

Each question on the application was completed by the applicant(s). The applicant has received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

I agree with the answer given for Question 12, "Will the term life benefit replace any existing life insurance?" (If the response shown for Question 12 does not reflect your understanding, please check this box and attach an explanation.)

X _____
Signature of Licensed Broker

X _____
Print Full Name

7437846
Broker Number

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.

reporting agency, or MIB, Inc., formerly known as 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.

I certify that:

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.

- (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.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

If you cannot certify to either (a) or (b) above, you are not eligible to apply for this plan.

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.

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.

ANI-0709

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-

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, consumer-reporting agency, MIB, Inc., formerly known as 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 (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

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.

I (we) understand the following:

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.

- 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 OptumHealth Bank)

By signing to the right, I acknowledge that:

- I wish to establish a health savings account (HSA) with OptumHealth Bank as custodian.
- I understand the eligibility requirements for deposits made to my HSA and state that I qualify to make deposits to this account. I have reviewed this application and understand and agree that my HSA will be opened under and governed by OptumHealth Bank's Custodial and Deposit Agreement and that the terms and conditions therein will be binding on me. This document will be sent to me when my account is opened, along with OptumHealth Bank's Privacy Policy and Schedule of Fees.
- I authorize OptumHealth Bank to provide information about my HSA, including my account number, to Golden Rule, and those acting on behalf of Golden Rule or OptumHealth 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, may provide information on my behalf to establish and maintain my HSA and authorize Golden Rule and its designee to take such action deemed necessary and appropriate by Golden Rule to administer my HSA, including but not limited to, making deposits and correcting errors where necessary.
- I understand my monthly account statements will be made available to me electronically. I agree to notify OptumHealth Bank if I wish to have statements mailed to my home address.
- I have requested a MasterCard Prepaid Debit Card and if I have filled out the information to request an Authorized User debit card, I hereby request OptumHealth 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 OptumHealth Bank to share information about my HSA with the Authorized User named and to allow any account transactions made by such Authorized User.
- I certify that the information provided in this application is true and complete.

X _____
Signature of Primary Applicant

Primary Applicant's Social Security Number _____

Applicant's Spouse Social Security Number _____

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.

REQUEST FOR AN AUTHORIZED USER DEBIT CARD (OPTIONAL)

Authorized User's _____
First Name Middle Initial

Authorized User's _____
Last Name

Authorized User's _____
Date of Birth

Authorized User's _____
Social Security No.

155X-1108

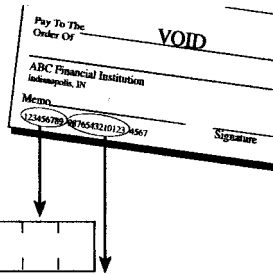
ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION — ONLY IF PAYING BY EFT

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

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.

X _____
Authorized Account Signature

Email Address _____

INITIAL PAYMENT CREDIT CARD AUTHORIZATION

I authorize FACT or Golden Rule to bill my MasterCard/Visa 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 Exp. Date: _____
Month Year

Card Number: _____

X _____
Signature of Authorized User

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

IMPORTANT INFORMATION

Before You Submit Your Application:

- If you were previously insured by UnitedHealthcare or any of its companies, you still must complete this application fully and accurately.
- Read the applicable product brochure(s).
- Altered applications will not be accepted.
- Brokers must be licensed with Golden Rule in the state where an application is signed and the state where the primary applicant resides.
- **Coverage is not available if:**
 - Any family member, whether or not named in this application, is currently pregnant; or
 - The applicant has not resided in the U.S. for at least 12 consecutive months.

Important Information:

- Any person who knowingly presents false, incomplete, or misleading information in an application for insurance may be committing insurance fraud.
- You must disclose your full health history and the full health history of all applicants listed on the application. Even if your application is approved, any omissions or false statements may result in future claims being denied and/or termination or rescission of coverage.
- Include all requested details and explanations. If you need to include additional information, attach an extra sheet of paper. Include your signature and date on the extra sheet.
- Do not cancel any existing coverage you might have until you are notified that your application has been approved.