Benefits Manager, Inc

Instructions For Golden Rule

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Benefits Manager, Inc for review along with the completed application. If you do not have access to a fax machine, send the completed application to Benefits Manager, Inc along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- ❑ Indicate your requested effective date.
- ❑ Select your preferred billing method.
- ❑ Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also sign and date the authorization form.

Don't forget to **enclose the initial premium and FACT dues check made payable to "FACT".**

Mail completed application and check to:

Benefits Manager, Inc
Attn: New Enrollment
1235 W. Stone Creed Ln.
Layton, UT 84041

Benefits Manager, Inc will review your application for completeness and accuracy before we submit it to Golden Rule for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at (888)310-9623 or e-mail us at mikeoliphant@benefitsmanager.net.

Benefits Manager, Inc

Application Process FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:

Benefits Manager, Inc

FAX# (801)444-7389

Dear Benefits Manager, Inc,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application

Name ____

E-mail ____

Date ____

Time ____

☐ Please contact me at this phone number ______________________after you have reviewed my application for completeness and accuracy.

☐ I will contact Benefits Manager, Inc at (888)310-9623 to verify receipt of my application.

**I understand that Benefits Manager, Inc will not review this application until the following weekday morning if I faxed this application after 5:00PM or on a weekend

I understand that the original signed application must still be mailed to Benefits Manager, Inc. I will mail the original signed application to :

Benefits Manager, Inc
Attn: New Enrollment
1235 W. Stone Creed Ln.
Layton, UT 84041

I will send the original application as soon as I have been contacted by Benefits Manager, Inc with confirmation that my application has been received by fax and reviewed for completeness.

Signature: ________________________________ Date: _______________

FACT MEMBERSHIP ENROLLMENT FORM (If not already a member)

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 0304

REVIEW BEFORE MAILING THE APPLICATION

Be sure:

- To read the current product brochure before completing the application for insurance.

Note:

- If you were previously insured by United Healthcare (UHC), you must still fully complete this application accurately. Our underwriters do not have access to UHC underwriting and claims files.
- Broker must be licensed with Golden Rule in state where application is signed AND state where applicant resides.
- Coverage is not available if:
  - any family member is currently pregnant; or
  - the applicant has not resided in the U.S. for the last 12 consecutive months.
- Altered applications will not be accepted.
- Any person who knowingly presents false, incomplete, or misleading information in an application for insurance may be committing insurance fraud.
- The applicant will be notified of the actions taken within 45 days after the date of the application, or be given the reason for delay.
- There is no coverage until approved in writing by Golden Rule.
- **P.O. Boxes are not accepted as a Primary Resident Address.**
- **Applications received by Golden Rule more than 15 days after the signed date will not be accepted.**

Mail the Application and Related Forms Packet to the address below.

Be sure to include the following:

- Health Insurance Illustration.
- Initial premium and FACT dues check made payable to "FACT."
- P.A.C. authorization and voided check (if paying monthly).

Mail to: Golden Rule Insurance Company
HEALTH APPLICATION
Home Office
712 Eleventh Street
Lawrenceville, Illinois 62439-2395

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 (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.

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

Signed X____/____/____ at ______________________ X______________________
Date City State Signature of Primary Applicant (You)

X______________________ X______________________
Signature of Parent/Guardian (if You are a minor) Signature of Spouse (if to be covered)

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)		❑ M ❑ S						
2. Spouse								

3. Dependent Children	Name (Last, First, M.I.)	Social Security Number	Birth Date	Age	Sex	Height	Weight
a.							
b.							
c.							
d.							
e.							

4. Primary Applicant's Address **(P.O. Boxes are not accepted.)**

Street ______ City ______ State ______ Zip ______

5. Phone Numbers: ( ) ______ ( ) ______ ______
Daytime Evening Best times to call

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: ______

Prior Employment (If within 2 years): ______

9. Total Annual Household Income: ❑ $15,000 or less ❑ $15,001 to $35,000 ❑ $35,001 to $50,000 ❑ $50,001 to $75,000 ❑ $75,001 to $99,999 ❑ $100,000 or more

COVERAGE INFORMATION

10. Plan:

- ❑ Copay 25℠ Plan
  - ❑ 80/20 of $10,000
  - ❑ 70/30 of $10,000
  - ❑ 50/50 of $ 8,000
- ❑ Copay 35℠ Plan
  - ❑ 80/20 of $10,000
  - ❑ 70/30 of $10,000
  - ❑ 50/50 of $ 8,000
- ❑ Copay 45℠ Plan
  - ❑ 80/20 of $10,000
  - ❑ 70/30 of $10,000
  - ❑ 50/50 of $ 8,000
- ❑ Plan 100®
- ❑ Plan 80℠
- ❑ Basic Plan℠
- ❑ HSA 100℠ Plan
- ❑ HSA 80℠ Plan

Deductible: ______ Requested Effective Date: ______/ ______/ ______

Optional Benefits: ❑ Prescription Drug Card ❑ Supplemental Accident ❑ Term Life Rider

Requested Health Class:	Preferred	Standard	Tobacco (If question 30 is yes.)
Primary	❑	❑	❑
Spouse	❑	❑	❑

PPO Option: Plan includes Full PPO; if not wanted, check here. ❑ No PPO

Optional Benefits:
- ❑ Prescription Drug Card
- ❑ Supplemental Accident
- ❑ Term Life Rider
- ❑ Maximum Maternity Benefit
  ❑ $2,500 ❑ $4,000
- ❑ HSA Indemnity Benefit (Not available with the $1,000/$2,000 deductibles.)

Special Instructions: ______

 Primary Applicant's initials ______ Spouse's initials ______ Date ___/___/___

BILLING (or attach health insurance illustration)

11. ❑ Monthly P.A.C. ❑ Quarterly ❑ List Bill (include list-bill forms)

Premium Amount		______				
FACT Dues	+	3.00				
Prescription Drug Card	+	______	Optional			
Supplemental Accident	+	______	Optional			
Term Life Benefit	+	______	Optional			
Maternity Benefit	+	______	Optional			
HSA Deposit	+	______	$25 Monthly Minimum (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
HSA Indemnity Rider	+	______		+	______	HSA Indemnity Rider
Payment With App.	= $	______	Make check payable to "FACT."	= $	______	**Payment With App.**

Initial Premium and FACT Dues Credit Card Authorization

I authorize Golden Rule to bill my VISA/MASTERCARD account for full initial Premium and FACT dues. **If quarterly billing requested, full initial premium will be for three months.** ❑ Visa ❑ MasterCard Exp. Date____/____

X ______________________________

Signature of credit cardholder

OTHER COVERAGE

		Yes	No
12.	Within the last 63 days, has any applicant **been covered by** any type of **medical** insurance? If yes, complete chart below. **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

		Yes	No
13.	Will the term life benefit replace any existing **life** insurance? Company Name ______________ Policy #________	❑	❑
14.	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.)	❑	❑

Person: ______________ Company: ______________ Action Taken: ______________

Date: ______________ Reason for Action: ______________

		Yes	No
15.	Has any applicant previously applied for, or been covered by, Golden Rule? . . . . If yes, who? ______________ Policy/Certificate # ______________	❑	❑

DRIVING

		Yes	No
16.	In the last 24 months, has any applicant participated in driving any type of motorcycle?	❑	❑
	If yes, please answer the following questions:		
	a. Name of applicant(s)? ______________		
	b. Does the applicant have a valid motorcycle license?	❑	❑
	c. Within the last 24 months, has the applicant had his/her license suspended or revoked?	❑	❑
	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."	❑	❑

Primary Applicant's initials ________ Spouse's initials ________ Date ___/___/___

MEDICAL HISTORY -- FOR ALL APPLICANTS

IMPORTANT! PLEASE PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS."

Yes No

17. Is any family member (whether or not named in this application) pregnant or an expectant mother or father? ❑ ❑
18. Do any applicants, other than dependent children, **not** read, write, speak, and understand the English language? ❑ ❑
19. Do you have an adoption pending? ❑ ❑
20. **In the last 6 months**, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind? ❑ ❑
21. **Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:**
    a. gallbladder? ❑ ❑
    b. pancreas or liver? ❑ ❑
    c. joints or spine? ❑ ❑
    d. kidney? ❑ ❑
    e. eyes, ears, or nose? ❑ ❑
    f. mouth, throat, or jaw? ❑ ❑
22. **In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:**
    a. high blood pressure? ❑ ❑
    b. chest pain? ❑ ❑
    c. headaches? ❑ ❑
    d. paralysis? ❑ ❑
    e. arthritis? ❑ ❑
    f. convulsions or epilepsy? ❑ ❑
    g. elevated cholesterol? ❑ ❑
    h. sexually transmitted disease? ❑ ❑
    i. cancer? ❑ ❑
    j. diabetes or sugar in the blood or urine? ❑ ❑
    k. stroke? ❑ ❑
    l. tumor, cyst, polyp, lump, or growth of any kind? ❑ ❑
    m. mental, emotional, or behavioral disorder? ❑ ❑
23. **In the last 10 years, has any applicant:**
    a. had a complicated pregnancy or delivery? ❑ ❑
    b. tested positive for antibodies to the HIV virus? ❑ ❑
    c. been hospital confined, had surgery, or discussed surgery? ❑ ❑

Yes No

24. **In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:**
    a. heart or circulatory system? ❑ ❑
    b. nervous system? ❑ ❑
    c. digestive system? ❑ ❑
    d. muscular or skeletal system? ❑ ❑
    e. respiratory system? ❑ ❑
    f. male or female reproductive system, including infertility? ❑ ❑
    g. urinary system? ❑ ❑
    h. thyroid, breast, or other glands? ❑ ❑
25. In the last 10 years, has any applicant had, been diagnosed as having, or been treated for, Acquired Immune Deficiency Syndrome (AIDS), or any HIV-related disease illness? ❑ ❑
26. 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? ❑ ❑
27. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more? ❑ ❑
28. 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? ❑ ❑
29. Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks per week? ❑ ❑
    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).
30. 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 10.) ❑ ❑
31. 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	Symptoms or Condition	Dates	Treatment, Advice Given, Results, and Other Details	Name, Address, and Phone # of Doctors, Hospitals, etc.

Feb 4 2004 10:18:22 am
GRI-AP-109-42 Primary Applicant's initials ______ Spouse's initials ______ Date ___/___/___ 984C-0304

MEDICAL HISTORY DETAILS -- FOR ALL APPLICANTS (cont.)

Question Number	Person	Symptoms or Condition	Dates	Treatment, Advice Given, Results, and Other Details	Name, Address, and Phone # of Doctors, Hospitals, etc.

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

STATEMENT OF UNDERSTANDING: Review the completed application and read the section below carefully before signing.

I certify that I have personally completed this application. I represent that the answers and statements on this application are true, complete, and correctly recorded. **I Understand and Agree** that: **(1)** this application and the payment of the initial premium do not give me immediate coverage; **(2)** unless Golden Rule agrees to an earlier date, coverage for illness begins on the 15th day after a person becomes insured for injury; **(3)** with respect to health coverage, there will be no benefits for any loss incurred in the first year of coverage due to a preexisting condition; **(4) an intentional misrepresentation of a material fact on this application may result in voidance of coverage or claim denial, subject to the Time Limit on Certain Defenses provision or the Incontestability provision; (5)** this completed application, and any supplements or amendments, will be made a part of any policy/certificate which may be issued; **(6)** the broker is only authorized to submit the application and initial premium, and may not change or waive any right or requirement; and **(7) continuation of other coverage existing on the Golden Rule effective date for more than 90 days after the Golden Rule effective date will void this coverage.** I have received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

Signed X _____/_____/_____ at __________________________
Date City State

X __________________________________
Signature of Primary Applicant (You)

X __________________________________
Signature of Parent/Guardian (if You are a minor) Relationship

X __________________________________
Signature of Spouse (if to be covered)

GRI-AP-109-42

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 13, "Will the term life benefit replace any existing **life** insurance?" (If the response shown for Question 13 does not reflect your understanding, please check this box and attach an explanation. ❑)

X __________________________________
Signature of Licensed Broker

X Mike Oliphant
Print Full Name

116-6920
Broker Number

Feb 4 2004 10:18:22 am

984C-0304

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 from me (or either of us) of its termination.

Checking Account # ____________________

X ____________________
(Signature of Payor, If not You)

Financial Institution's Name ____________________

Address ____________________

____

City, State, Zip ____________________

Draft On ____________________
Day

X ____________________
(Date Signed)

Attach Voided BLANK check here!

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.

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.

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 person, employer, insurance company, consumer-reporting agency, or the Medical Information Bureau (MIB) having nonmedical information about 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 above: Monthly P.A.C. Authorization, Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.

Signed X ____/____/____ at ____________________
Date 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) AGREEMENT AND ADOPTION (only if depositing HSA money with Golden Rule)

I wish to establish an HSA with Golden Rule as custodian and direct that my contributions be deposited in my Golden Rule HSA. I adopt the current Golden Rule Custodial Agreement and agree to its terms.

I understand the following:

1) Golden Rule has no responsibility for the tax treatment of my HSA.
2) I may revoke the HSA Custodial Agreement for any reason within seven days after I receive a copy of the Custodial Agreement.
3) If the Custodial Agreement is revoked by me, I will not be charged a set-up fee nor any monthly fees and agree that no interest will be paid on the money returned.
4) My Golden Rule HSA will credit interest on money in my account.
5) Golden Rule will set up my account and begin crediting interest the later of: a) 10 days after issue of the qualified medical Insurance; or b) the effective date of my qualified medical insurance.
6) Interest will not begin to accrue until funds are deposited with Golden Rule's agent bank.
7) Golden Rule or its agent bank may deduct usual administrative fees from my account and these fees may change on 60 days' prior notice.
8) The Custodial Agreement and Disclosure Notice are subject to change and may be changed as necessary to comply with the law.

The primary insured on the qualified Golden Rule medical insurance will be the accountholder of this HSA. If my spouse has signed this agreement, I authorize my spouse to withdraw funds from my HSA.

Required Certification: Under penalties of perjury, I certify that (1) my Social Security number shown on the application is correct; and (2) I am not subject to backup withholding and elect not to have any withholding apply. (Cross out and initial (2) if you have been notified that you were subject to backup withholding.)

Have you, within the last 6 months, been covered under another health insurance plan? ❑ Yes ❑ No Has your spouse? ❑ Yes ❑ No

If not applying for health insurance, but authorized to withdraw HSA Funds:

Spouse's Social Security Number __ __ __ – __ __ – __ __ __ __

Spouse's Date of Birth ____________________

X ____________________
Signature of Primary Applicant

X ____________________
Signature of Spouse

984C-0304

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Feb 4 2004 10:18:22 am