

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.

**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			Birth Date	Age	Sex	Height	Weight
Name (Last, First, M.I.)							
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 times to call Email Address

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: _____ 9. Total Annual Household Income: \$15,000 or less \$35,001 to \$50,000 \$75,001 to \$99,999
 Prior Employment (If within 2 years): _____ Household Income: \$15,001 to \$35,000 \$50,001 to \$75,000 \$100,000 or more

Primary Applicant's initials _____ Spouse's initials _____ Date ____ / ____ / ____



COVERAGE INFORMATION

10. Requested Effective Date: ___/___/____ Special Instructions: _____
 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.
 Plans issued with an effective date less than 30 days after the application received date will include a 14-day wait for illness coverage.
 All plans include a preferred network. Network Name: _____

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

Tobacco Use: **Primary** Yes **Spouse** Yes **Child a.** Yes **Child b.** Yes **Child c.** Yes **Child d.** Yes **Child e.** Yes (See Question 34 for applicants age 18 and older, including dependent children.)

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

<input type="checkbox"/> Copay SelectSM <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 Coinsurance — Out-of-Pocket Maximum After Deductible <input type="checkbox"/> 0% <input type="checkbox"/> 80/20 — \$3,000 <input type="checkbox"/> 70/30 — \$5,000 <hr/> <input type="checkbox"/> Plan 100[®] <input type="checkbox"/> Plan 80SM <input type="checkbox"/> Saver 80SM <input type="checkbox"/> \$1,000 (Saver 80 only) <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000 <hr/> <input type="checkbox"/> HSA 100[®] <input type="checkbox"/> HSA 70SM <input type="checkbox"/> \$1,250 (Single Only) <input type="checkbox"/> \$2,500 (Single and Family) <input type="checkbox"/> \$3,000 (Single Only) <input type="checkbox"/> \$3,500 (Single Only) <input type="checkbox"/> \$5,000 (Single and Family) <input type="checkbox"/> \$6,000 (Family Only) <input type="checkbox"/> \$7,000 (Family Only) <input type="checkbox"/> \$10,000 (Family Only)	FACT Membership Dues (Basic \$4, Choice \$20, Elite \$40): \$ _____ Base Premium Amount + _____ OPTIONAL BENEFITS — See current brochure and inserts for availability <input type="checkbox"/> \$25 Office Visit Copay + _____ Optional <input type="checkbox"/> 4-Dr. Office Visit Copay - _____ Optional <input type="checkbox"/> Prescription Drug — \$200 Deductible + _____ Optional <input type="checkbox"/> Prescription Drug — Copay Card + _____ Optional <input type="checkbox"/> Prescription Drug — Discount Card Only - _____ Optional <input type="checkbox"/> Prescription Drug — Generic Only - _____ Optional <input type="checkbox"/> Supplemental Accident: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 + _____ Optional <input type="checkbox"/> Term Life: Primary <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 + _____ Optional <input type="checkbox"/> Term Life: Spouse <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 + _____ Optional <input type="checkbox"/> Accidental Death: Primary + _____ Optional <input type="checkbox"/> Accidental Death: Spouse + _____ Optional <input type="checkbox"/> UnitedHealthcare Vision + _____ Optional <input type="checkbox"/> Mental Disorders and Substance Abuse + _____ Optional <hr/> <input type="checkbox"/> HSA Deposit + _____ \$25 Monthly Min.
	Total Monthly Payment = \$ _____ One-Time HSA Set-Up Fee + _____ \$10 Initial Monthly Payment (Payable to "FACT") = \$ _____ <hr/> If Quarterly, Total Monthly Payment x 3 = \$ _____ One-Time HSA Set-Up Fee + _____ \$10 Initial Quarterly Payment (Payable to "FACT") = \$ _____

11. **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.

OTHER COVERAGE

12. 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.

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

13. Will the term life benefit replace any existing **life** insurance? Company Name _____ Policy # _____ Yes No

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.) Yes No
 Person: _____ Company: _____ Action Taken: _____
 Date: _____ Reason for Action: _____

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

DRIVING -- FOR ALL APPLICANTS

16. 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)? Primary Spouse Child a. Child b. Child c. Child d. Child e.
 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?.....
 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."

MEDICAL HISTORY -- FOR ALL APPLICANTS

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

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 17. Is any family member (whether or not named in this application) pregnant or an expectant mother or father? | <input type="checkbox"/> | <input type="checkbox"/> | 27. In the last 5 years, has any applicant had any indication, signs, or symptoms of, or in the last 10 years, has any applicant been diagnosed as having or been treated for, any disease, disorder or abnormality of the: | | |
| 18. Do any applicants, other than dependent children, not 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"/> |
| 19. Do you have an adoption pending?..... | <input type="checkbox"/> | <input type="checkbox"/> | b. nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 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? | <input type="checkbox"/> | <input type="checkbox"/> | c. digestive system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Within the last 5 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the: | | | d. muscular or skeletal system?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| a. joints or spine?..... | <input type="checkbox"/> | <input type="checkbox"/> | e. respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. eyes, ears, or nose?..... | <input type="checkbox"/> | <input type="checkbox"/> | f. male or female reproductive system, including infertility? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. mouth, throat, or jaw?..... | <input type="checkbox"/> | <input type="checkbox"/> | g. urinary system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Within the last 5 years, has any applicant been diagnosed as having or been treated for any disease or disorder of the: | | | h. thyroid, breast, or other glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> | 28. In the last 5 years, has any applicant had any indication, or symptoms of, or in the last 10 years, has any applicant been diagnosed as having or been treated for, Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| b. pancreas or liver? | <input type="checkbox"/> | <input type="checkbox"/> | 29. In the last 5 years, has any applicant had any indication, signs, or symptoms of any other disease, disorder, injury, or adverse finding? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. kidney?..... | <input type="checkbox"/> | <input type="checkbox"/> | 30. In the last 10 years, has any applicant been diagnosed as having or been treated for any other disease, disorder, injury, or adverse finding, or had any adverse abnormal test result? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. In the last 5 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of: | | | 31. 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"/> |
| a. high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | 32. 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"/> |
| b. chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | 33. 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"/> |
| c. headaches? | <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). | | |
| d. paralysis?..... | <input type="checkbox"/> | <input type="checkbox"/> | 34. 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.) | <input type="checkbox"/> | <input type="checkbox"/> |
| e. arthritis? | <input type="checkbox"/> | <input type="checkbox"/> | 35. 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. | | |
| f. convulsions or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| g. sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| h. tumor, cyst, polyp, lump, or growth of any kind? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 24. In the last 5 years, has any applicant been diagnosed as having or been treated for: | | | | | |
| a. elevated cholesterol?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| b. diabetes or sugar in the blood or urine? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| c. stroke? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| d. mental, emotional, or behavioral disorder?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 25. In the last 10 years, has any applicant: | | | | | |
| a. tested positive for antibodies to the HIV virus?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| b. been hospital confined, had surgery, or discussed surgery?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| c. been diagnosed as having or been treated for cancer?..... | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 26. In the last 5 years, has any applicant: | | | | | |
| a. had a complicated pregnancy or delivery? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| b. consulted a mental health professional? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

