

Liles Insurance Brokerage.com

Application 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 Liles Insurance Brokerage.com for review along with the completed application. If you do not have access to a fax machine, send the completed application to Liles Insurance Brokerage.com 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 complete, sign, and date the authorization form.

Don't forget to **enclose the initial premium and FACT dues check made payable to "FACT" (does not apply to CT, DE, GA, KS, and LA).**

Mail completed application and check to:

Liles Insurance Brokerage.com

Attn: New Enrollment

1002 Saint Blaise Trail

Gallatin, TN 37066

Liles Insurance Brokerage.com 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 615-504-4753 or e-mail us at jeff@lilesinsurancebrokerage.com.

Norvax form #IN-1

Liles Insurance Brokerage.com

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:**

Liles Insurance Brokerage.com

FAX# 615-230-7782

Dear Liles Insurance Brokerage.com,

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

Name _____

E-mail _____

Date _____

Time _____



Time _____

_____ after you have reviewed my application for completeness and accuracy.



I will contact Liles Insurance Brokerage.com at 615-504-4753 to verify receipt of my application.

****I understand that Liles Insurance Brokerage.com will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to Liles Insurance Brokerage.com. I will mail the original signed application to :

Liles Insurance Brokerage.com

Attn: New Enrollment

1002 Saint Blaise Trail

Gallatin, TN 37066

I will send the original application as soon as I have been contacted by Liles Insurance Brokerage.com with confirmation that my application has been received by fax and reviewed for completeness.

Norvax form #CS-1

FACT MEMBERSHIP ENROLLMENT FORM

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 0105

**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 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: 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): \$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 30 is yes)
 Plan includes Preferred Network; if not wanted, check here Spouse: Preferred Standard Tobacco (if question 30 is yes)

Network Name: _____

Copay Plans	<input type="checkbox"/> Copay Select SM <input type="checkbox"/> \$ 500	HSA Plans	Single <input type="checkbox"/> HSA 100 [®] <input type="checkbox"/> \$1,050	Family <input type="checkbox"/> \$ 2,100	High Deductible	<input type="checkbox"/> Plan 100 [®] <input type="checkbox"/> \$ 500 (Saver 80 only)
	<input type="checkbox"/> \$1,000		<input type="checkbox"/> HSA Saver [®] <input type="checkbox"/> \$1,800	<input type="checkbox"/> \$ 3,650		<input type="checkbox"/> Plan 80 SM <input type="checkbox"/> \$1,500 (Saver 80 only)
	<input type="checkbox"/> \$1,500		<input type="checkbox"/> \$2,700	<input type="checkbox"/> \$ 5,450		<input type="checkbox"/> Saver 80 SM <input type="checkbox"/> \$2,500
	<input type="checkbox"/> \$2,500		<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$ 7,500		<input type="checkbox"/> \$3,500
	<input type="checkbox"/> Copay Saver SM <input type="checkbox"/> \$2,000		<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000		<input type="checkbox"/> \$5,000
Optional	<input type="checkbox"/> Term Life Benefit	Optional	<input type="checkbox"/> Term Life Benefit		Optional	<input type="checkbox"/> Term Life Benefit <input type="checkbox"/> Preventive Care
	<input type="checkbox"/> Preventive Care (Not Available with Copay Select)		<input type="checkbox"/> Preventive Care			<input type="checkbox"/> Supplemental Accident
	<input type="checkbox"/> Supplemental Accident		<input type="checkbox"/> Hospital Indemnity Rider			<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 Maximum Maternity
	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 Maximum Maternity					<input type="checkbox"/> Prescription Drug Card (Not Available with Saver 80)

BILLING (or attach health insurance quote)

12. Initial Payment With Application
 Check P.A.C. (EFT with on-line app. only) Credit Card →

Ongoing Payments
 Monthly P.A.C. (EFT) Quarterly Direct Bill

FACT Dues \$ 3.00

Base Premium Amount + _____

Term Life Benefit + _____ Optional

Preventive Care + _____ Optional

Supplemental Accident + _____ Optional

Maternity Benefit + _____ Optional

Prescription Drug Card + _____ 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

One-Time HSA Indemnity Rider + _____ One-Time HSA Indemnity Rider

Initial Payment = \$ _____ Make check payable to "FACT:" = \$ _____ **Initial Payment** ←

Initial Payment Credit Card Authorization

I authorize FACT or 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: _____
 Month Year

Security Code _____ (last 3 digits in signature line)

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 (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

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

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 # _____

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

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)? _____ Yes No
- 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"/> | 24. In the last 10 years, has any applicant: | | |
| 19. Do any applicants, other than dependent children, not read, write, speak, and understand the English language? | <input type="checkbox"/> | <input type="checkbox"/> | a. had a complicated pregnancy or delivery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have an adoption pending? | <input type="checkbox"/> | <input type="checkbox"/> | b. tested positive for antibodies to the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. 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. been hospital confined, had surgery, or discussed surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the: | | | 25. 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. gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> | a. heart or circulatory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. pancreas or liver? | <input type="checkbox"/> | <input type="checkbox"/> | b. nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. joints or spine? | <input type="checkbox"/> | <input type="checkbox"/> | c. digestive system? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. kidney? | <input type="checkbox"/> | <input type="checkbox"/> | d. muscular or skeletal system? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. eyes, ears, or nose? | <input type="checkbox"/> | <input type="checkbox"/> | e. respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. mouth, throat, or jaw? | <input type="checkbox"/> | <input type="checkbox"/> | f. male or female reproductive system, including infertility? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of: | | | g. urinary system? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | h. thyroid, breast, or other glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 27. 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"/> |
| d. paralysis? | <input type="checkbox"/> | <input type="checkbox"/> | 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? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. arthritis? | <input type="checkbox"/> | <input type="checkbox"/> | 29. 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"/> |
| f. convulsions or epilepsy? | <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). | | |
| g. elevated cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | 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 11.) | <input type="checkbox"/> | <input type="checkbox"/> |
| h. sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> | 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. | | |
| 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. Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| m. tumor, cyst, polyp, lump, or growth of any kind? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| n. mental, emotional, or behavioral disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

**This form must be signed and returned to GOLDEN RULE INSURANCE COMPANY with all applications.
TENNESSEE PORTABILITY CERTIFICATION**

INSTRUCTIONS (You may be eligible for a portability plan -- guarantee issue without preexisting conditions limits.)

PART I Review the statements and sign where appropriate.

PART II, PART III, PART IV Review and complete only if you sign under B. in Part I.

PART I ELIGIBILITY INFORMATION (Decide whether or not all of the statements 1-6 apply to you.)

1. I do not have any other health insurance coverage (or it will be involuntarily terminated soon).
2. I have been insured by *creditable coverage*¹ (as defined below) for the last 18 months or more with no lapse in coverage of more than 63 days.
3. My most recent coverage was under a *group health plan*² (as defined below), a governmental plan, or a church plan.
4. My most recent coverage was not terminated due to nonpayment of premiums, fraud, or intentional misrepresentations.
5. I am not eligible for any coverage under a *group health plan*² (as defined below), Medicare, or Medicaid.
6. I accepted and exhausted any group continuation of coverage (including COBRA) that was offered to me -- or -- I was not offered group continuation of coverage (including COBRA).

Carefully review the statements above and sign below where appropriate.

A. One or more of the six statements above **do not** apply to me.

Signature _____ Date _____

If you signed under A, go to page 7.

-- OR --

B. I represent that all six of the statements above **do** apply to me.

Signature _____ Date _____

If you signed under B, answer the questions below and complete the rest of this form.

How many employees work for the employer that most recently provided your health insurance? _____
 Were you eligible for COBRA or group continuation of coverage? YES NO
 If yes, did you maintain COBRA or group continuation until it expired? YES NO

PART II PLAN DESIGN, PRICE, AND AVAILABILITY (Plan 100®, Preferred Network, \$2,500 deductible or HSA 100®, Preferred Network, \$2,700/\$5,450 deductible)

How does portability affect plan design?

Portability plans: 1) do not include a 12-month rate guarantee; 2) do not apply preexisting conditions limitations; 3) do not offer the optional benefits typically available with the plan; and 4) have higher premium rates.

What happens if a family applies and not all are eligible for portability?

Those who are eligible will be considered for a portability plan, and those not eligible will be subject to underwriting for a plan without portability rights.

How are premiums calculated?

Initial rates are higher for portability plans. Rates may increase substantially (up to 200%) after underwriting -- see To Calculate Payment.

What if only one or two family members want to apply for a portability plan and the others want to be underwritten for a plan without portability rights?

Complete two separate applications, and we will consider the family members under two separate plans. Children are not required to apply with their parent, but may apply separately.

To Calculate Payment:

Total Monthly Payment	_____
(Rate from your Insurance Representative)	
Preexisting Waiver Factor	x 1.10
Monthly Minimum Total	= _____
	x 2.00
Monthly Maximum Total	= _____

¹*Creditable coverage* includes group or individual health insurance coverage, Medicare, Medicaid, Armed Forces coverage, Indian or tribal coverage, state risk pool coverage, public health coverage, and Peace Corps Act coverage. A plan is NOT *creditable coverage* if it: a) provides coverage only for accidents, disability, or liability; b) is credit-only insurance; or c) is secondary to other insurance.

²Generally, a *group health plan* is any coverage existing in connection with employment. Included are: employer-sponsored plans (so long as at least one employee participates); coverage of an employee under an individual policy of insurance that is part of a plan, fund, or program established or maintained by an employer that provides medical care to employees or their dependents; coverage of a business owner so long as at least one employee other than the business owner and the business owner's spouse also participates in the plan; and coverage of partners in a plan maintained by the partnership.

PART III APPLICATION (You must sign and date in ONE of the boxes below if you signed under B. in Part I.)

Applying for a Portability Plan (guaranteed-issue coverage)

I signed under B. in Part I because all six statements under Part I apply to me. While I understand that Golden Rule makes the final determination regarding eligibility, I am applying for a portability plan. My signature below confirms that my portability rights were explained, and the minimum and maximum rates were made available to me.

X _____
Signature of Proposed Insured

X _____
Date

Not Applying for a Portability Plan (guaranteed-issue coverage)

Even though I believe I am eligible for a portability plan, I am not applying for a portability plan. My signature below confirms that my portability rights were explained; portability coverage was offered; the minimum and maximum rates were made available, and I do not wish to pursue this option at this time.

I realize if I am eligible and I do not apply for a portability plan within 62 days of losing my group coverage, this right may no longer be available to me.

X _____
Signature of Proposed Insured

X _____
Date

PART IV PROOF OF CREDITABLE COVERAGE (Complete ONLY if you are applying for a portability plan.)

Option 1

- 1) Provide the information requested below; and
- 2) Provide copies of "certificates of creditable coverage" as evidence of coverage under each health plan for the past 18 months. *Certificates of creditable coverage* are available from your prior health insurance administrators.

OR

Option 2

- 1) Provide the information requested below; and
- 2) Provide copies of "supporting documents" as evidence of coverage under each health plan for the past 18 months. *Supporting documents* may include copies of the following: identification card, explanation of benefits, pay stubs showing a deduction for health coverage, insurance certificate, and/or cancelled premium payment checks.

Details About Your Most Recent Coverage

Details About Your Most Recent Coverage				
Most Recent Employer Name and Address		Employment Termination Date		Phone No.
Most Recent Insurance Company Name and Address		Effective Date	Termination Date	Phone No.
Other Insurance Companies for the Past 18 Months		Effective Date	Termination Date	Phone No.

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

I (we) hereby authorize FACT or 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.

Routing No. _____

Checking Account No. _____

Include Voided BLANK check!

Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____

Day

(Date Signed)

X _____

(Signature of Account Holder)

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 health 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.

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.

002C-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: Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.

Signed X _____ / _____ / _____ at _____ City _____ State

X _____
 Signature of Parent/Guardian (If You are a minor)

X _____
 Signature of Primary Applicant (You)

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.

Signed X _____ / _____ / _____ at _____ City _____ State

X _____
 Signature of Parent/Guardian (If You are a minor)

X _____
 Signature of Primary Applicant (You)

X _____
 Signature of Spouse (If to be covered)

HEALTH SAVINGS ACCOUNT (HSA) APPLICATION (only if opening an HSA with Exante)

By signing below, I acknowledge that:

- I wish to establish an HSA with Exante Bank as custodian.
- I understand and agree that my HSA will be opened under and governed by Exante Bank's Custodial and Deposit Agreement. Terms of this Agreement will be binding on me unless I close my account within 30 days. This document will be sent to me when my account is opened, along with Exante Bank's Privacy Policy and Schedule of Fees and Charges.
- I authorize Exante Bank to provide information about my HSA, including my account number, to Golden Rule, and those acting on behalf of Golden Rule or Exante 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 (if applicable), may provide information on my behalf to establish and maintain my HSA.
- I understand my monthly account statements will be made available to me electronically. I agree to notify Exante Bank if I wish to have statements mailed to my home address.
- If I have filled out the information to request an additional debit card, I hereby request Exante 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 certify that the information provided in this application is true and complete.

X _____
 Signature of Primary Applicant
 Primary Applicant's
 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.

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

REQUEST FOR AN ADDITIONAL 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-0606

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 UnitedHealthcare, you must still fully complete this application accurately. Our underwriters do not have access to UnitedHealthcare 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 quote.
- Initial payment check made payable to "FACT."
- P.A.C. authorization and voided check (if paying monthly).

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