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)	❑M ❑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 (Include Apt.) 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: _____ You will be the beneficiary for your spouse.

Name Relationship Age

8. Your Occupation: _____ Date Hired: _____ 9. Total Annual ❑$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

10. Primary Applicant's Mother's Maiden Name: _____ Spouse's Mother's Maiden Name: _____

(Last Name Only) (Last Name Only)

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

COVERAGE INFORMATION

11. **Requested Health Class:** Primary: ❑ Preferred ❑ Stand. I ❑ Stand. II
Spouse: ❑ Preferred ❑ Stand. I ❑ Stand. II

Tobacco Use: **Primary** ❑ Yes **Spouse** ❑ Yes **Child a.** ❑ Yes **Child b.** ❑ Yes **Child c.** ❑ Yes **Child d.** ❑ Yes **Child e.** ❑ Yes

(See Question 30 for applicants age 18 and older, including dependent children)

Requested Effective Date: __ __/__ __ / __ __ __ __
Plan includes Preferred Network; if not wanted, check here ❑
Network: _____
Special Instructions: _____

Copay Plans

❑ Copay Select℠ ❑ $ 500 ❑ $1,000 ❑ $1,500 ❑ $2,500 ❑ $5,000
❑ Copay Saver℠ ❑ $2,500 ❑ $5,000

HSA Plans

	Single	Family
❑ HSA 100®	❑ $1,100	❑ $ 2,200
❑ HSA Saver®	❑ $1,850	❑ $ 3,800
	❑ $2,850	❑ $ 5,650
	❑ $3,500	❑ $ 7,500
	❑ $5,000	❑ $10,000

Plan 80, Plan 100, and Saver 80

❑ Saver 80℠ ❑ $ 500 (*Saver 80* only)
❑ Plan 80℠ ❑ $1,000 (*Saver 80* only)
❑ Plan 100® ❑ $1,500 ❑ $2,500 ❑ $3,500 ❑ $5,000

Optional

❑ Term Life Benefit ❑ Maternity
❑ Supplemental Accident ❑ $500 ❑ $1,000
❑ Preventive Care (*Copay Saver* only)
❑ 2 Additional Dr. Visits a Year (*Copay Saver* only)
❑ Prescription Drug-no annual max. (*Copay Select only*)
❑ Lifetime Maximum-$5 Million

Optional

❑ Term Life Benefit
❑ Preventive Care
❑ Hospital Indemnity Rider
(Not Available with $1,100 or $2,200 deductible)
❑ Lifetime Maximum-$5 Million

Optional

❑ Term Life Benefit ❑ Maternity
❑ Supplemental Accident ❑ $500 ❑ $1,000
❑ Preventive Care
❑ Prescription Drug Card (Not with *Saver 80*)
❑ Lifetime Maximum-$5 Million

BILLING (or attach health insurance quote)

12. **Initial Payment With Application**: ❑ Check ❑ EFT (with online app. only) ❑ Credit Card
Ongoing Payments: ❑ Monthly (EFT) ❑ List Bill (include forms)
❑ Quarterly Direct Bill

FACT Dues	$	3.00	
Base Premium Amount	+		
Term Life Benefit	+		Optional
Maternity Benefit	+		Optional
Supplemental Accident	+		Optional
Preventive Care	+		Optional
2 Additional Dr. Visits a Year	+		Optional
Prescription Drug-no annual max.	+		Optional
Prescription Drug Card	+		Optional
Lifetime Maximum-$5 Million	+		Optional
HSA Deposit	+		$25 Monthly Minimum (only with HSA)
Child(ren) Admin. Fee	+		$5 per month (only if primary applicant <18 yrs)
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.) ..... ❑ ❑
Person: Company: Action Taken:

Date: Reason for Action:

16. Has any applicant previously applied for, or been covered by, Golden Rule? ..... ❑ ❑
If yes, who? _____ Policy/Certificate # _____

DRIVING -- FOR ALL APPLICANTS

		Yes	No
17.	In the last 24 months, has any applicant participated in driving any type of motorcycle?	❑	❑

If yes, please answer the following questions:

		Primary	Spouse	Child a.	Child b.	Child c.	Child d.	Child e.
a.	Which applicant(s)?	❑	❑	❑	❑	❑	❑	❑
b.	Does applicant have a valid motorcycle license?	❑Yes	❑Yes	❑Yes	❑Yes	❑Yes	❑Yes	❑Yes

		Yes	No
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."	❑	❑

MEDICAL HISTORY -- FOR ALL APPLICANTS

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

		Yes	No
18.	Is any family member (whether or not named in this application) pregnant or an expectant mother or father?	❑	❑
19.	Do any applicants, other than dependent children, **not** read, write, speak, and understand the English language?	❑	❑
20.	Do you have an adoption pending?	❑	❑
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?	❑	❑
22.	**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?	❑	❑
23.	**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.	Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness?	❑	❑
m.	tumor, cyst, polyp, lump, or growth of any kind?	❑	❑
n.	mental, emotional, or behavioral disorder?	❑	❑

		Yes	No
24.	**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?	❑	❑
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.	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?	❑	❑
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 11.)	❑	❑
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 Conditions	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)** there will be no benefits for any loss incurred in the first year of coverage due to a preexisting condition; **(4) incorrect or incomplete information on this application may result in voidance of coverage or claim denial; (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.

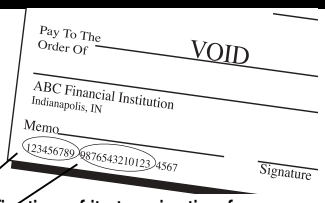
Signed X _____/_____/_____ at _____ X _____
Date City State Signature of Primary Applicant (You)

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

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 depository 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.



Nine-digit Check Routing No. _____

Checking 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.

Account Holder's Signature X _____

E-mail Address _____

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 employer, insurance company, government agency, consumer-reporting agency, or the 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.

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 _____ 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)

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)

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 14, "Will the term life benefit replace any existing **life** insurance?" (If the response shown for Question 14 does not reflect your understanding, please check this box and attach an explanation. ❑)

X _____
Signature of Licensed Broker

Broker Number

X _____
Print Full Name

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 authorize Exante to share information about my HSA with the authorized user named and to allow withdrawals by check, debit card, or other means to be 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 ___ ___ ___ – ___ ___ – ___ ___ ___ ___

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 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-0806

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."
- EFT authorization and voided check (if paying via EFT).

Mail to: Golden Rule Insurance Company
HEALTH APPLICATION
PO Box 68994
Indianapolis, Indiana 46268-0994

IMPORTANT PORTABILITY NOTICE

You may be eligible to receive credit toward the preexisting condition provision. Submit proof of creditable coverage from plans that were in force during the prior 12 months. We will advise you what portion, if any, of the preexisting condition limitation will be waived.