Please Print
in Black Ink

APPLICATION FOR SHORT TERM MEDICAL℠ INSURANCE
GOLDEN RULE INSURANCE COMPANY — INDIANAPOLIS, INDIANA 46278-1719

PROPOSED INSURED

First | Middle Initial | Last | Height | Weight | Birth Date * | Age | ☐ Male ☐ Female

Resident Physical Address (where you live and pay taxes). PO Boxes are not accepted.

Street (Include Apt.) | City | State | ZIP | ( ) Telephone No.

Mailing Address (if different than Resident Address)

Street (Include Apt.) | City | State | ZIP

Email Address _____

Proposed Insured | Spouse (if to be covered)

1. List below any dependents to be covered under the policy/certificate.

Dependent's Name (Last, First, M.I.)	Relationship	Height	Weight	Date of Birth*	
	Spouse			/ /	☐ M ☐ F
				/ /	☐ M ☐ F
				/ /	☐ M ☐ F
				/ /	☐ M ☐ F
				/ /	☐ M ☐ F
				/ /	☐ M ☐ F

*If born within 30 days prior to the effective date of coverage, the person will not be covered under the policy/certificate.

		Yes	No
2.	Are you or is any family member (whether or not named in this application) an expectant mother or father, in the process of adopting a child, or undergoing infertility treatment?..... **If yes, coverage cannot be issued.**	☐	☐
3.	Have you or has anyone named in Question 1 been declined for insurance due to health reasons?..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy/certificate.)	☐	☐
4.	Have you or has any person named in Question 1 lived in the 50 states of the USA or the District of Columbia for **less than** the past 12 months? If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy/certificate.)	☐	☐
5.	Do you or does any person named in Question 1 now have hospital or medical expense insurance that **will not** terminate..... prior to the requested effective date? If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy/certificate.)	☐	☐
6.	Within the last 5 years, have you or has anyone listed on the application received medical or surgical consultation, advice, or treatment, including medication, for **any of the following:** blood disorders, liver disorders, kidney disorders, chronic obstructive pulmonary disorder (COPD) or emphysema, diabetes, cancer, heart or circulatory system disorders (excluding high blood pressure), Crohn's disease or ulcerative colitis, or alcohol or drug abuse or immune system disorders?..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy/certificate.)	☐	☐
7.	Within the last 5 years, have you or has anyone listed on the application received treatment, advice, medication, or surgical consultation for HIV infection from a doctor or other licensed clinical professional, or had a positive test for HIV infection performed by a doctor or other licensed clinical professional?..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy/certificate.)	☐	☐
8.	Have you or has any person named in Question 1 had testing performed and has not received results, or been advised by a medical professional to have treatment, testing, or surgery that has not been performed? ..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy/certificate.)	☐	☐

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PLAN: ☐ **Short Term Medical℠ Plus Elite** ☐ **Short Term Medical℠ Copay** ☐ **Short Term Medical℠ Copay Value**
☐ **80/20 - $2,000** **70/30 - $10,000** **70/30 - $10,000**
☐ **70/30 - $5,000**
☐ **Short Term Medical℠ Plus** ☐ **Short Term Medical℠ Value**
☐ **80/20 - $2,000** ☐ **70/30 - $5,000**
☐ **70/30 - $5,000** ☐ **70/30 - $10,000**

REQUESTED EFFECTIVE DATE:
_____/_____/_____
(See Statement of Understanding section.)

DEDUCTIBLE: ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $10,000

DAYS OF COVERAGE: _____ (30-360 Days)

OPTIONAL BENEFITS:
☐ Supplemental Accident Benefit ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $10,000
☐ Per Cause Deductible

PRESCRIPTION DRUGS *(You may only choose one.)*:
☐ Prescription Drug - Add 4 Tier Rx Coverage *(Available with Short Term Medical℠ Copay Plan only)*
☐ Prescription Drug - Add a Generic $20 Rx Copay *(Available with all Plans except Short Term Medical℠ Value)*
☐ Prescription Drug - Remove Rx Coverage *(Available with Short Term Medical℠ Copay Plan only)*
☐ Prescription Drug - Add Rx Coverage *(Available with Short Term Medical℠ Copay Value Plan only)*

STATEMENT OF UNDERSTANDING

I have read this application and represent that the information shown on it is true and complete. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule with this application; (b) no benefits will be paid for a health condition that exists prior to the date insurance takes effect; and (c) if coverage is issued, the coverage will not be a continuation of any prior coverage. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy/certificate that may be issued. I understand that for an application sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after receipt by Golden Rule. I understand that for a mailed application, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after the **postmark date** affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (i) the requested effective date; or (ii) the date received by Golden Rule. I understand that the broker is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

X _____ X _____
Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child — Date you signed and read application

X _____ _____ _____
Spouse (if to be covered) — Licensed Agent or Broker (Please Print) — Individual Producer #

Important Notes:
- **"Postmark date" means the date of the postmark as affixed by the U.S. Postal Service.**
- **No application will be accepted if received by Golden Rule more than 15 days after the date signed.**
- **Altered applications will not be accepted.**

STM-AP-160G-GRI

To Continue Your Application for Coverage, You Must Become A Member Of FACT

Read and fill out the following FACT Membership Enrollment Form.

FACT MEMBERSHIP ENROLLMENT FORM

I hereby enroll for Basic ($4 a month) 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 Application for Short Term Medical 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.

X _____ _____
Member's Signature — Date

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

FACT ENFO STM 0216

PAYMENT OPTIONS: SINGLE OR MONTHLY (Initial Payment Method Required With Application)

Electronic Funds Transfer (EFT) and Credit Card payment will be collected on the date we issue coverage, or the effective date of the policy, whichever is later. If coverage is not issued, we will collect EFT or Credit Card payment for the nonrefundable application fee on the date of our decision.

☐ **Single Payment** (one single payment for all days of coverage chosen):

- ☐ **EFT $ Amount** _____ Includes $20 nonrefundable application fee.
  Please complete the EFT Authorization below.
- ☐ **Credit card $ Amount** _____ Includes $20 nonrefundable application fee.
  Please complete the Credit Card Authorization below.
- ☐ **Check or money order $ Amount** _____ Includes $20 nonrefundable application fee.
  Please mail your check or money order, payable to FACT, with your application. Checks are deposited upon receipt.

OR

☐ **Monthly Payment:** (Based on 30 days of coverage.) Final Premium Payment may be less due to less than 30 days of coverage remaining.

Initial Payment ☐ EFT (Ongoing payment must be EFT.) ☐ Credit Card ☐ Check or money order
Please mail your check or money order, payable to FACT, with your application. Checks are deposited upon receipt.

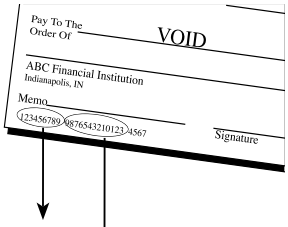
$ Amount _____ Initial Payment amount (shown) includes a one-time $20 nonrefundable application fee.

Ongoing Payments (Choose one)

- ☐ **Direct Bill** ($10 monthly billing fee.)
  Ongoing monthly Direct Bill payments will not include the $20 application fee, however they will include a $10 monthly billing fee.
- ☐ **Electronic Funds Transfer** (EFT) (No billing fee.)
  Ongoing monthly EFT payments will not include the $20 application fee.
- ☐ **Credit Card** (No billing fee.)
  Ongoing monthly Credit Card payments will not include the $20 application fee.

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

I (we) hereby authorize FACT or Golden Rule to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account. I agree this authorization will remain in effect until you actually receive written notification of its termination from me.



Type of Account: ☐ Checking ☐ Savings

Nine-digit Routing No. _____

Account No. _____

Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____ / / _____
Day Date Signed

X _____
Authorized Account Signature

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.

CREDIT CARD AUTHORIZATION — COMPLETE ONLY IF PAYING BY CREDIT CARD

Credit Card Authorization ☐ Visa ☐ MasterCard ☐ American Express

I authorize FACT or Golden Rule Insurance Company to charge my Visa/MasterCard/American Express account for the Single Payment or Monthly Payment above.

_____ / _____ / _____ _____ X _____
Account No. Expiration Date Billing ZIP Code Signature of Authorized User

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

Charge On _____ (29th, 30th, 31st not available)
Day

PAYOR INFORMATION (If other than Proposed Insured)

Payor: _____
Name Email Address

_____
Street City State ZIP

( ) _____
Contact Number

CONSENT TO RECEIVE ELECTRONIC RECORDS AND TO CONDUCT TRANSACTIONS ELECTRONICALLY

By submitting this consent form or a health insurance application or HMO enrollment form, you hereby consent to presentation, delivery, storage retrieval and transmission of "Communications" related to "Our Transaction" as electronic records instead of in paper form.

For the purposes of this form, "Our Transaction" means the entirety of the business relationship between you and us. "Communications" includes, but is not limited to:

1. Your application or enrollment form, including subsequent amendments;
2. Information related to Our Transaction that we are required to provide or make available in writing such as privacy notices or fraud warnings;
3. Documents related to Our Transaction such as policy, certificate, or evidence of coverage forms, claim forms, explanation of benefit forms, premium notices, or other administrative forms (to the extent permitted by applicable law);
4. Any emails, faxes, recorded telephone calls, or other electronic transmissions of information between you and us and an insurance producer contracted with us, or between us and any third party.

Subject to our obligations to protect your privacy, we may, at our sole discretion, post Communications on a website (in which case they will be sent or received, as the case may be, regardless of whether or not we own, operate or control the website). Or send them in or attached to an email. You must promptly tell us about any change to your electronic or physical mailing address, or other contact information.

You acknowledge that you can receive or access Communications because you have the following:

- A telephone
- A computer and printer
- A device or computer program for listening to audio CDs, mp3, WAV or other common computer audio files
- An Internet browser
- Access to the Internet
- A valid email address
- Adobe Acrobat Reader or other sufficient PDF reader

You can request a free copy of any Communications, or withdraw your consent to receive electronic Communications at any time by sending a written request to:

Policy Administration
PO Box 31372
Salt Lake City, UT 84131-0372

☐ I hereby consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. All of the Communications between the time you submit your consent and withdraw your consent will remain valid and binding on both you and us notwithstanding your withdrawal.

☐ I hereby DO NOT consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. If you do not consent, we will conduct all future business with you in paper form.

X _____
Primary Applicant *(You)*

X _____
Parent/Guardian *(if you are a minor)* Relationship

_____
Primary Applicant *(You)* Email Address

X _____
Parent/Guardian *(if you are a minor)* Email Address

_____
Date