

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
LAWRENCEVILLE, IL 62439
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)

| Last | Name First | M.I. | Marital Status | Social Security Number | Birth Date | Age | Sex | Height | Weight |
|---------------|------------|------|--|------------------------|------------|-----|-----|--------|--------|
| 1. | | | <input type="checkbox"/> M <input type="checkbox"/> S | | | | | | |
| Primary (You) | | | | | | | | | |
| 2. | | | | | | | | | |
| Spouse | | | | | | | | | |

| 3. Dependent Children | Last | Name First | M.I. | Birth Date | Age | Sex | Height | Weight |
|-----------------------|------|------------|------|------------|-----|-----|--------|--------|
| a. | | | | | | | | |
| b. | | | | | | | | |
| c. | | | | | | | | |
| d. | | | | | | | | |

4. Primary Resident Address: _____

5. Phone Numbers: _____
 Street (Include Apt.) _____ City _____ State _____ ZIP _____
 Home _____ Other _____ Best number and times to call _____

6. Payor (If not You): _____
 Name _____ Street _____ City _____ State _____ ZIP _____

7. Your Beneficiary: _____ 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. Requested Effective Date: ___/___/____
 All plans include a preferred network; if not wanted, check here Special Instructions: _____
 Network Name: _____

Requested Health Class: Primary: Preferred Standard I Standard II
 Spouse: Preferred 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 26 for applicants age 18 and older, including dependent children.)

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



AVAILABLE PRODUCTS

HIGH DEDUCTIBLE PLANS

- Plan 100[®] \$ 500 (Saver 80 only)
- Plan 80SM \$1,000 (Saver 80 only)
- Saver 80SM \$1,500 \$2,500 \$3,500
- \$5,000

COPAY PLANS

- Copay SelectSM \$ 500 (Copay Select only)
- \$1,000 (Copay Select only)
- Copay SaverSM \$1,500 \$2,500 \$5,000

HSA PLANS

- | | | |
|---|----------------------------------|-----------------------------------|
| | <u>Single</u> | <u>Family</u> |
| | <u>2008</u> | <u>2008</u> |
| <input type="checkbox"/> HSA 100 [®] | <input type="checkbox"/> \$1,100 | <input type="checkbox"/> \$2,200 |
| | <input type="checkbox"/> \$1,900 | <input type="checkbox"/> \$3,850 |
| | <input type="checkbox"/> \$2,900 | <input type="checkbox"/> \$5,800 |
| <input type="checkbox"/> HSA Saver [®] | <input type="checkbox"/> \$3,500 | <input type="checkbox"/> \$7,500 |
| | <input type="checkbox"/> \$5,000 | <input type="checkbox"/> \$10,000 |

OPTIONAL BENEFITS

- Term Life Benefit

- Lifetime Maximum - \$5 Million
- Supplemental Accident (Not available with HSA Plans):
 \$500 \$1,000
- Preventive Care (Not available with Copay Select)
- 2 Additional Dr. Visits a Year (Copay Saver only)
- Prescription Drug - no annual max. (Copay Select only)
- Prescription Drug Card (Plan 100 and Plan 80 only)
- HSA Hospital Indemnity Rider (Not available with \$1,100 or \$2,200 deductibles)

BILLING -- THIS SECTION ONLY TO BE COMPLETED BY BROKER (or attach software illustration).

11. **Initial Payment With Application:** Check EFT Credit Card
Ongoing Payments: Monthly (EFT) Quarterly Direct Bill

FACT Dues \$ 3.00
 Base Premium Amount + _____
 Term Life Benefit + _____ Optional

Lifetime Maximum-\$5 Million + _____ Optional
 Supplemental Accident + _____ Optional
 Preventive Care + _____ Optional
 2 Additional Dr. Visits a Year + _____ Optional
 Prescription Drug-no annual max. + _____ Optional
 Prescription Drug Card + _____ Optional

HSA Deposit + _____ \$25 Monthly Minimum
 (only with HSA)
 Child(ren) Admin. Fee + _____ \$5 Monthly
 (only if primary applicant <18 yrs)

Total Monthly Payment = \$ _____
 One-Time HSA Set-Up Fee + _____ \$10 (only with HSA)
 One-Time HSA Indemnity Rider + _____ Optional (only with HSA)
Initial Payment = \$ _____ Make check payable to "FACT"

If Quarterly, Total Monthly Payment x 3 = \$ _____
 One-Time HSA Set-Up Fee + _____ \$10 (only with HSA)
 One-Time HSA Indemnity Rider + _____ Optional (only with HSA)
Initial Payment = \$ _____ Make check payable to "FACT"

IMPORTANT: Premium will be verified and may be adjusted up or down during the underwriting process.

OTHER COVERAGE

12a. Within the last 62 days, has any applicant **been covered by**, or has application been made for, any type of **medical** insurance? If yes, Yes No
 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 |
|------------------|--------------|---------------------------|---|-------------------------|------------------|
| | | | | | |
| | | | | | |
| | | | | | |

b. Will this plan replace any existing **life** insurance? Company Name _____ Policy # _____ Yes No

c. In the last 7 years, 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

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

DRIVING

13. 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? Yes No

MEDICAL HISTORY -- FOR ALL APPLICANTS

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

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|--|--------------------------|--------------------------|
| 14. Is any family member (whether or not named in this application) pregnant or an expectant mother or father? | <input type="checkbox"/> | <input type="checkbox"/> | 20. In the last 7 years, has any applicant: | | |
| 15. 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"/> |
| 16. 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"/> |
| 17. 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"/> |
| 18. Within the last 7 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the: | | | 21. In the last 7 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"/> |
| 19. In the last 7 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"/> | 22. In the last 7 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"/> | 23. 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"/> | 24. 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"/> | 25. 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"/> | 26. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? | <input type="checkbox"/> | <input type="checkbox"/> |
| h. sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> | 27. 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 below. | | |
| 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"/> | | | |

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 12b, "Will the term life benefit replace any existing life insurance?" (If the response shown for Question 12b 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 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.

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.

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.

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.

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.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

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.

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.

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 employer, insurance company, government agency,

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

Signed X _____ at _____
Date 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, consumer-reporting agency, 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 (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

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.

- 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.

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 have retained a copy of this authorization.

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

Signed X _____ at _____
Date 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)

