

COVERAGE INFORMATION

11. Requested Effective Date: ___/___/___ Requested Health Class: Primary: Preferred Standard Tobacco (if question 32 is yes)
 Plan includes Preferred Network; if not wanted, check here Spouse: Preferred Standard Tobacco (if question 32 is yes)
 Network Name: _____ Special Instructions: _____

Copay Plans	<input type="checkbox"/> Copay Select SM	<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500	HSA Plans	Single 2007/2008	Family 2007/2008	High Deductible	<input type="checkbox"/> Plan 100 [®]	<input type="checkbox"/> \$ 500 (Saver 80 only)
	<input type="checkbox"/> Copay Saver SM	<input type="checkbox"/> \$2,500		<input type="checkbox"/> HSA 100 [®]	<input type="checkbox"/> \$1,100/\$1,100 <input type="checkbox"/> \$1,850/\$1,900 <input type="checkbox"/> \$2,850/\$2,900 <input type="checkbox"/> \$3,500/\$3,500 <input type="checkbox"/> \$5,000/\$5,000		<input type="checkbox"/> \$2,200/\$2,200 <input type="checkbox"/> \$3,800/\$3,850 <input type="checkbox"/> \$5,650/\$5,800 <input type="checkbox"/> \$7,500/\$7,500 <input type="checkbox"/> \$10,000/\$10,000	<input type="checkbox"/> Plan 80 SM
Optional	<input type="checkbox"/> Preventive Care (Not with Copay Select) <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 Maximum Maternity <input type="checkbox"/> Supplemental Accident <input type="checkbox"/> Mental Disorder Benefit (Not with Copay Saver)			<input type="checkbox"/> Preventive Care <input type="checkbox"/> Hospital Indemnity Rider (Not Available with \$1,100 or \$2,200 deductible) <input type="checkbox"/> Mental Disorder Benefit (Not with HSA Saver)		Optional	<input type="checkbox"/> Preventive Care <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 Maximum Maternity <input type="checkbox"/> Supplemental Accident <input type="checkbox"/> Prescription Drug Card (Not with Saver 80) <input type="checkbox"/> Mental Disorder Benefit (Not with Saver 80)	

BILLING (or attach health insurance quote)

12. Initial Payment With Application:
 Check EFT Credit Card
 Ongoing Payments:
 Monthly (EFT) Quarterly Direct Bill List Bill (include forms)

Initial Payment Credit Card Authorization
 I authorize 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: _____
 Name as Printed on Card _____
 Billing Address _____ City _____ State _____ ZIP _____
 Card Number _____
 X _____
 Signature of Authorized User

Base Premium Amount + _____
 Preventive Care + _____ Optional
 Maternity Benefit + _____ Optional
 Supplemental Accident + _____ Optional
 Prescription Drug Card + _____ Optional
 Mental Disorder Benefit + _____ Optional
 HSA Deposit + _____ \$25 Monthly Minimum (only with HSA)
Total Monthly Payment = \$ _____
 One-Time HSA Set-Up Fee + _____ \$10 only with HSA
 One-Time HSA Indemnity Rider + _____
Initial Payment = \$ _____ Make check payable to "Golden Rule."

If Quarterly → **X3= \$ _____** **Total Quarterly Payment**
 + _____ One-Time HSA Set-Up Fee
 + _____ One-Time HSA Indemnity Rider
Initial Payment ←

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 (6) 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 **N/A**
 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 # _____

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)? _____
- 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"/> | 25. In the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the: | | |
| 19. 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"/> |
| 20. Do you have an adoption pending? | <input type="checkbox"/> | <input type="checkbox"/> | b. nervous system? | <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. digestive system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Within the last 10 years, has any applicant had any known 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. gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> | e. respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. pancreas or liver? | <input type="checkbox"/> | <input type="checkbox"/> | f. male or female reproductive system, including infertility? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. joints or spine? | <input type="checkbox"/> | <input type="checkbox"/> | g. urinary system? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. kidney? | <input type="checkbox"/> | <input type="checkbox"/> | h. thyroid, breast, or other glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. eyes, ears, or nose? | <input type="checkbox"/> | <input type="checkbox"/> | 26. In the last 10 years, has any applicant had any signs, symptoms, diagnosis, or treatment of any Acquired Immune Deficiency Syndrome (AIDS)? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. mouth, throat, or jaw? | <input type="checkbox"/> | <input type="checkbox"/> | 27. In the last 10 years, has any applicant tested positive for antibodies to the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. In the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of: | | | 28. In the last 10 years, has any applicant had any known 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"/> |
| a. high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | 29. 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"/> |
| b. chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | 30. 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"/> |
| c. headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 31. 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"/> |
| d. paralysis? | <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). | | |
| e. arthritis? | <input type="checkbox"/> | <input type="checkbox"/> | 32. 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"/> |
| f. convulsions or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> | 33. 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. | | |
| g. elevated cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| h. sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 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. tumor, cyst, polyp, lump, or growth of any kind? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| m. mental, emotional, or behavioral disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 24. In the last 10 years, has any applicant: | | | | | |
| a. had a complicated pregnancy or delivery? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| b. been hospital confined, had surgery, or discussed surgery? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

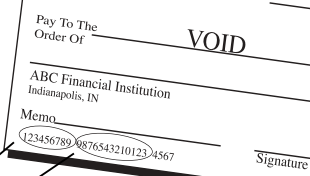
ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION -- ONLY IF PAYING BY EFT

I (we) hereby authorize 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.

I understand that my premium cannot be paid with an employer check unless I am certifying under (a) above, or my employer has set up a list bill account with Golden Rule.

By signing below, I certify that I understand I am applying for personal health insurance that may never be used as employer-provided insurance.

074C-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 Monthly P.A.C. Authorization and the Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.

Signed X _____ / _____ / _____ at _____ City State

X _____ Signature of Primary Applicant (You)

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

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 Primary Applicant (You)

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

X _____ Signature of Spouse (if to be covered)

