

APPLICATION FOR SHORT TERM MEDICAL INSURANCE
GOLDEN RULE INSURANCE COMPANY -- LAWRENCEVILLE, ILLINOIS 62439

No application will be accepted if received by Golden Rule at its Home Office or Indianapolis Office more than 15 days after the date signed.

PROPOSED INSURED

First Middle Initial Last Social Security Number Birth Date Age Sex (Male/Female)

RESIDENT ADDRESS

Street City State ZIP Telephone No.

1. Are any of your dependents to be covered under the policy/certificate? Yes No If Yes, give details below.

Table with 7 columns: Dependent's First Name, Relationship to You, Social Security Number, Date of Birth, Dependent's First Name, Relationship to You, Date of Birth. Includes entries for Spouse and N/A.

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

- 2. Are you or is any family member... an expectant mother or father?
3. Have you or anyone named above been declined for insurance due to health reasons?
4. Have you or 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?
5. Do you or any person named in Question 1 now have hospital or medical expense insurance that will not terminate prior to the requested effective date?
6. Within the last 5 years, have you or anyone listed on the application received medical or surgical consultation, advice, or treatment... for any of the following: liver disorders, kidney disorders, emphysema, diabetes, cancer, heart or circulatory system disorders... or alcohol or drug abuse?
7. Within the last 5 years, have you or anyone listed on the application been diagnosed with or treated for immune system disorders, including HIV infection, or tested positive for HIV infection?

DEDUCTIBLE: \$ 250 \$ 500 \$1,000 \$1,500 \$2,500 REQUESTED EFFECTIVE DATE: / / (See Statement of Understanding section below.)

MONTHS OF COVERAGE: 1 MO. 2 MO. 3 MO. 4 MO. 5 MO. 6 MO.

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 at its Home Office 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.

Signature lines for Proposed Insured's Signature or Parent/Legal Guardian, State where you signed this application, Date you signed and read application, Licensed Agent or Broker, Individual Producer #

ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

Important Note: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service.

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 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 Short Term Medical Insurance to FACT.

X _____
Member's Signature

X _____
Date

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

FACT ENFO STM 0105

Payment Options: *Must choose one*

Single Payment: Check or money order \$ Amt. _____ (Total Single Payment on reverse)
For this method of payment, you must make check or money order payable to FACT. (EFT also available with on-line application)

OR

Single Payment: Credit card \$ Amt. _____ (Total Single Payment on reverse)
For this method of payment, you must complete the Credit Card Authorization below.

Credit Card Authorization Visa MasterCard

I authorize FACT or Golden Rule Insurance Company to bill my Visa/MasterCard account for the total payment.

Account No.

Expiration Date ____/____/____

Security Code ____
(Last 3 digits in signature line)

Name on Credit Card

X _____
Signature of Authorized User

Phone No. _____

Billing Address _____ City _____ State _____ ZIP _____

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

OR

Monthly Payment: Electronic Funds Transfer (EFT) \$ Amt. _____ (Total Initial Payment on reverse)
The amount shown includes a one-time \$20 Application Fee. Additional monthly EFT payments will be \$20 less.
For this method of payment, you must complete the EFT Authorization below.

Electronic Funds Transfer (EFT) Authorization

I hereby authorize FACT or Golden Rule Insurance Company 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 of its termination.

Checking Account No. _____

Financial Institution

Name _____ Address _____

City _____ State _____ ZIP _____

Account Holder (Printed Name)

Name _____ Address _____

City _____ State _____ ZIP _____

Draft On _____ of each month X _____
Day Signature of Account Holder -- As shown on the account to which this authorization is applicable Phone No. _____

Date

IMPORTANT: BE SURE TO INCLUDE A VOIDED BLANK CHECK OR A BLANK DEPOSIT SLIP FOR YOUR CHECKING ACCOUNT WITH THIS AUTHORIZATION.