

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)	<input type="checkbox"/> M <input type="checkbox"/> S						
2. Spouse							
3. Dependent Children Name (Last, First, M.I.)			Birth Date	Age	Sex	Height	Weight
a.	Not Required						
b.	Required						
c.	Not Required						
d.	Required						
e.	Not Required						

4. Primary Applicant's Address (P.O. Boxes are not accepted.)

 Street 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: Name Relationship Age You will be the beneficiary for your spouse.

8. Your Occupation: _____ Date Hired: _____ 9. Total Annual Household Income: \$15,000 or less \$35,001 to \$50,000 \$75,001 to \$99,999
 Prior Employment (If within 2 years): _____ \$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)

DRIVING

- 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:**
- a. Name of applicant(s)? _____
- b. Does the applicant have a valid motorcycle license?
- 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 | | 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 diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness? | <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 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"/> |
| 23. In the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of: | | | 28. 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"/> |
| a. high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | 29. 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"/> |
| b. chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | 30. 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"/> |
| c. headaches? | <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). | | |
| d. paralysis? | <input type="checkbox"/> | <input type="checkbox"/> | 31. 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"/> |
| e. arthritis? | <input type="checkbox"/> | <input type="checkbox"/> | 32. 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. | | |
| f. convulsions or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 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. tested positive for antibodies to the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| c. been hospital confined, had surgery, or discussed surgery? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

PART III APPLICATION (You must sign and date in ONE of the boxes below if you signed under B. in Part I.)

Applying for a Portability Plan (guaranteed-issue coverage)

I signed under B. in Part I because all six statements under Part I apply to me. While I understand that Golden Rule makes the final determination regarding eligibility, I am applying for a portability plan. My signature below confirms that my portability rights were explained, and the minimum and maximum rates were made available to me.

X _____
Signature of Proposed Insured

X _____
Date

Not Applying for a Portability Plan (guaranteed-issue coverage)

Even though I believe I am eligible for a portability plan, I am not applying for a portability plan. My signature below confirms that my portability rights were explained; portability coverage was offered; the minimum and maximum rates were made available, and I do not wish to pursue this option at this time.

I realize if I am eligible and I do not apply for a portability plan within 63 days of losing my group coverage, this right may no longer be available to me.

X _____
Signature of Proposed Insured

X _____
Date

PART IV PROOF OF CREDITABLE COVERAGE (Complete ONLY if you are applying for a portability plan.)

Option 1

- 1) Provide the information requested below; and
- 2) Provide copies of "certificates of creditable coverage" as evidence of coverage under each health plan for the past 18 months. *Certificates of creditable coverage* are available from your prior health insurance administrators.

OR

Option 2

- 1) Provide the information requested below; and
- 2) Provide copies of "supporting documents" as evidence of coverage under each health plan for the past 18 months. *Supporting documents* may include copies of the following: identification card, explanation of benefits, pay stubs showing a deduction for health coverage, insurance certificate, and/or cancelled premium payment checks.

Details About Your Most Recent Coverage

Most Recent Employer Name and Address		Employment Termination Date		Phone No.
Most Recent Insurance Company Name and Address	Effective Date	Termination Date	ID No.	Phone No.
Other Insurance Companies for the Past 18 Months	Effective Date	Termination Date	ID No.	Phone No.

MONTHLY P.A.C. AUTHORIZATION -- ONLY IF PAYING BY MONTHLY P.A.C.

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 from me (or either of us) of its termination.

Routing No. _____

Checking Account No. _____

Include Voided BLANK check!

Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____ Day _____ (Date Signed)

X _____
(Signature of Account Holder)

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 person,

employer, insurance company, consumer-reporting agency, or the Medical Information Bureau (MIB) having nonmedical information about 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 _____ 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 (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 _____ 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)

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 certify that the information provided in this application is true and complete.

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 ADDITIONAL 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.

X _____
Signature of Primary Applicant
Primary Applicant's
Social Security Number _____

155X-0606

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"
- P.A.C. authorization and voided check (if paying monthly).

Mail to: Golden Rule Insurance Company
HEALTH APPLICATION
712 Eleventh Street
Lawrenceville, Illinois 62439-2395