

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 Lawrenceville or Indianapolis Office more than 15 days after the date signed.

PROPOSED INSURED
RESIDENT ADDRESS
First Middle Initial Last Birth Date Age Sex

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

Table with 6 columns: Dependent's First Name, Relationship to You, Date of Birth*, Dependent's First Name, Relationship to You, Date of Birth*. Includes 'Spouse' entry.

- 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...
5. Do you or any person named in Question 1 now have hospital or medical expense insurance...
6. Within the last 5 years, have you or anyone listed on the application received medical or surgical consultation...
7. Has any applicant: (a) tested positive for exposure to the HIV infection; (b) been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS)...

DEDUCTIBLE: \$ 250 \$ 500 \$1,000 \$1,500 \$2,500
REQUESTED EFFECTIVE DATE: / /

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

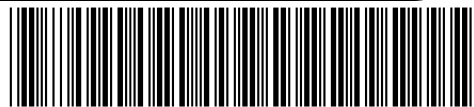
STATEMENT OF UNDERSTANDING

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 Lawrenceville or Indianapolis 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.

Any person who knowingly and with intent to injure, defraud or deceive any insurer files a statement of claim or an application containing any false, incomplete or misleading information is guilty of a felony of the third degree.

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

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



ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

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 _____ Date _____

E-mail Address: _____

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

FACT ENFO STM 0908

Payment Options: *Must choose one*

Single Payment: Check or money order \$ Amt. _____ (Total Single Payment on reverse. Includes \$20 nonrefundable application fee.)
 For this method of payment, you must make check or money order payable to FACT. (EFT also available with online application)

OR

Single Payment: Credit card \$ Amt. _____ (Total Single Payment on reverse. Includes \$20 nonrefundable application fee.)
 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 ____/____/____
 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. First month amount (shown) includes a one-time \$20 nonrefundable 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 (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. _____

Draft On _____
 Day _____

Financial Institution

Name: _____
 Address: _____
 City: _____
 State: _____ ZIP: _____

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

Name: _____
 Address: _____
 City: _____
 State: _____ ZIP: _____
 E-mail Address: _____
Authorized Account Signature: _____
 Date Signed: _____

