Health Insurance Options

Application Instructions for Golden Rule

1. Print all pages of the application including instructions
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Health Insurance Options for review along with the completed application. If you do not have access to a fax machine, send the completed application to Health Insurance Options along with the required first month's payment.

HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must complete, sign, and date the authorization form.

Don't forget to enclose the initial payment check made payable to:

- "FACT" for all states except CT, DE, GA, KS, KY, LA, NV, NM, SD, and WY
- "Golden Rule" for CT, DE, GA, KS, KY, LA, NV, NM, SD, and WY only

Mail completed applications and check to:

Health Insurance Options
Attn: New Enrollment
307 Oakwood Ct.

Fern Park, FL 32730

Health Insurance Options will review your application for completeness and accuracy before we submit it to Golden Rule for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at 407-265-3244 or e-mail us at joe@healthinsoptions.com.

Norvax form #IN-1

Health Insurance Options

Application Process FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**Please FAX this cover letter with the completed application to:
Health Insurance Options
FAX# 407-574-3095

Dear Health Insurance Options,
Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

☐ Please contact me at this phone number _____ after you have reviewed my application for completeness and accuracy.

☐ I will contact Health Insurance Options at 407-265-3244 to verify receipt of my application.

**I understand that Health Insurance Options will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend

I understand that the original signed application must still be mailed to Health Insurance Options. I will mail the original signed application to :

Health Insurance Options
Attn: New Enrollment
307 Oakwood Ct.

Fern Park, FL 32730

I will send the original application as soon as I have been contacted by Health Insurance Options with confirmation that my application has been received by fax and reviewed for completeness.

Norvax form #CS-1

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FACT Membership Enrollment Form **Florida**

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 _____

FACT ENFO 0105

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

GOLDEN RULE INSURANCE COMPANY
APPLICATION FOR INSURANCE

MUST BE COMPLETED BY THE APPLICANT(S) **PLEASE PRINT IN BLACK INK**

APPLICANT(S) INFORMATION

1. **REASON FOR APPLICATION:** ❑ New Application ❑ Add a dependent ❑ Child Only (list youngest child as the Primary Applicant) ❑ Reinstatement ❑ Change deductible

ID Number _____ (for additions, reinstatements, or deductible changes)

2. **PRIMARY APPLICANT'S INFORMATION:**

a. Name (Last, First, M.I.): _____

b. Mailing Address

Street (Include Apt.)

City State ZIP

c. **A physical address is required if different than your mailing address. P.O. Boxes are not accepted as a physical address.**

Physical Address

Street (Include Apt.)

City State ZIP

d. Phone Numbers: (____) Home (____) Other Best number and times to call E-mail Address

e. Payor: (If not You): Name E-mail Address

Street City State ZIP

f. Your Beneficiary: _____ You will be the beneficiary for your spouse.
Name Relationship Age

g. Your Occupation: _____ h. Marital Status: ❑ Married ❑ Single

i. 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

3. **APPLICANTS FOR COVERAGE:** Please list only those persons needing coverage.

Gender	Name (Last, First, M.I.)	Social Security No.	Birth Date	Age	✓ If Full-time Student*	MUST BE ACCURATE Height	MUST BE ACCURATE Weight
❑ Male ❑ Female	a. Primary (You)						
❑ Male ❑ Female	b. Spouse						
❑ Male ❑ Female	c. Child						
❑ Male ❑ Female	d. Child						
❑ Male ❑ Female	e. Child	NOT REQUIRED					
❑ Male ❑ Female	f. Child						
❑ Male ❑ Female	g. Child						

If you need to list additional dependents, please use lined paper, sign and date it, and check this box. ❑

*A full-time student is one who is enrolled in and attending an accredited college or university on a full-time basis.

4. Primary Applicant's Mother's Maiden Name: _____ (Last Name Only)
   Spouse's Mother's Maiden Name: _____ (Last Name Only)

5. Do all applicants, other than dependent children, read, write, speak, and understand the English language? . . . . . ❑ Yes ❑ No
   (A no answer does not eliminate an applicant from eligibility, but merely alerts us that a translator may be necessary for telephone conversations.)

COVERAGE INFORMATION — Must complete for all new applications, including child only.

6. Requested Effective Date: __ __/__ __ / __ __ __ __
7. All plans include a preferred network; if not wanted, check here ❑ Network Name: _____
8. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, indicate who below.) . . . . . ❑ Yes ❑ No

a. Primary	b. Spouse	c.Child	d. Child	e. Child	f. Child	g. Child
❑ Yes	❑ Yes	❑ Yes	❑ Yes	❑ Yes	❑ Yes	❑ Yes

9. **Requested Health Class:** Primary: ❑ Preferred ❑ Standard I ❑ Standard II
   Spouse: ❑ Preferred ❑ Standard I ❑ Standard II

10. **For additions and reinstatements, complete only if changing the deductible for all insureds.**

AVAILABLE PRODUCTS

HIGH DEDUCTIBLE PLANS

❑ Plan 100®	❑ $ 500 (*Saver 80* only)
❑ Plan 80℠	❑ $1,000
❑ Saver 80℠	❑ $1,500 ❑ $2,500 ❑ $3,500 ❑ $5,000

COPAY PLANS

❑ Copay Select℠	❑ $ 500 (*Copay Select* only)
	❑ $1,000 (*Copay Select* only)
❑ Copay Saver℠	❑ $1,500 ❑ $2,500 ❑ $5,000

HSA PLANS

	Single 2008	Family 2008
❑ HSA 100®	❑ $1,100	❑ $2,200
	❑ $1,900	❑ $3,850
	❑ $2,900	❑ $5,800
❑ HSA Saver®	❑ $3,500	❑ $7,500
	❑ $5,000	❑ $10,000

OPTIONAL BENEFITS

❑ Term Life Benefit

❑ Lifetime Maximum - $5 Million
❑ Maternity
(not available with HSA Plans)
❑ 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 deductible)

BILLING (or attach a health quote printout)

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

FACT Dues	**$** 3.00	
Base Premium Amount	+ _____	
Term Life Benefit	+ _____	Optional
Lifetime Maximum - $5 Million	+ _____	Optional
Maternity Benefit	+ _____	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 (only with HSA)	+ _____	$25 Monthly Minimum
Child(ren) Admin. Fee (only if primary applicant <18 yrs)	+ _____	$5 Monthly
Total Monthly Payment	**= $** _____	
One-Time HSA Set-Up Fee (only with HSA)	+ _____	$10
One-Time HSA Indemnity Rider (only with HSA)	+ _____	Optional
Initial Payment	**= $** _____	Make check payable to "FACT."
If Quarterly, Total Monthly Payment x 3	**= $** _____	
One-Time HSA Set-Up Fee (only with HSA)	+ _____	$10
One-Time HSA Indemnity Rider (only with HSA)	+ _____	Optional
Initial Payment	**= $** _____	Make check payable to "FACT."

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

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PREVIOUS OR CURRENT HEALTH INSURANCE COVERAGE (Completing this section may make you eligible for an earlier effective date for illnesses.)

Yes No

12. Within the last 63 days, has any applicant **been covered** by any type of **medical** insurance? . . . . . ❑ ❑
    If yes, complete chart below. **Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced (see (9) 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

Yes No

13. Will the term life benefit replace any existing **life** insurance? . . . . . ❑ ❑
    Company Name _____ Policy Number _____
14. Has any applicant ever had an application or policy voided, declined, rated, or had coverage modified (including medical exclusion riders) by any health or life insurer? (If yes, list name and give details.) . . . . . ❑ ❑
    Person: _____ Company: _____ Action Taken: _____
    Date: _____ Reason for Action: _____
15. Has any applicant previously applied for, or been covered by, Golden Rule or UnitedHealthcare? . . . . . ❑ ❑
    Name_____ Policy/Certificate Number _____

DRIVING — FOR ALL APPLICANTS

Yes No

16. In the last 24 months, has any applicant participated in driving any type of motorcycle? . . . . . ❑ ❑
    If yes, please answer the following questions:
    a. Which applicant(s)? ❑ **a. Primary** ❑ **b. Spouse** ❑ **c. Child** ❑ **d. Child** ❑ **e. Child** ❑ **f. Child** ❑ **g. Child**
    b. Does applicant have a valid motorcycle license? ❑ Yes ❑ Yes ❑ Yes ❑ Yes ❑ Yes ❑ Yes ❑ Yes
    c. Within the last 24 months, has the applicant had any motor vehicle license suspended or revoked? . . . . . ❑ ❑
    d. Within the last 24 months, has the applicant, while operating any 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! YOU MUST PROVIDE DETAILS OF EACH YES ANSWER IN THE "MEDICAL HISTORY DETAILS" SECTION.

Yes No

17. Are you, or is any family member (whether or not named in this application), pregnant or an expectant mother or father, or in the process of surrogate pregnancy, or do you or any family member have an adoption pending? . . . . . ❑ ❑
18. In the last 5 years, has any applicant filed a claim and/or received benefits from disability insurance or Worker's Compensation? ❑ ❑
19. Has any applicant had or been advised to have: (a) any testing (other than routine testing, such as pap or mammogram); or (b) any treatment, which has not yet been completed? . . . . . ❑ ❑
20. In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind? . . . . . ❑ ❑
21. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more? . . . . . ❑ ❑
22. In the last 5 years, has any applicant used an illegal drug; had any diagnosis or treatment of an alcohol or drug dependency, problem, or abuse; been advised to reduce alcohol intake; or had any alcohol- or drug-related moving violation, arrest, or driver's license suspension? . . . . . ❑ ❑
23. Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks* per week? . . . . . ❑ ❑
    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, or 1 oz. of hard liquor).

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MEDICAL HISTORY — FOR ALL APPLICANTS (continued)

24. In the last 10 years, has any applicant:	Yes	No
a. Had a complicated pregnancy or delivery (including a caesarean section)?	❑	❑
b. Consulted a health care provider for any condition or symptom(s) for which a diagnosis has not been established?	❑	❑
c. Has any applicant: (a) tested positive for exposure to the HIV infection; (b) been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) caused by HIV infection; or (c) been diagnosed as having any other sickness or condition derived from an HIV infection?	❑	❑
d. Had any abnormal physical exam, X-ray, EKG, MRI, CT scan, or any adverse or abnormal laboratory or other test results?	❑	❑
e. Been confined in a hospital for anything other than childbirth?	❑	❑
f. Had surgery?	❑	❑
g. Had placement, treatment, or maintenance of an internal or external implant or prosthetic device?	❑	❑

In the last 10 years, has any applicant had testing or additional tests recommended for, or had any signs, symptoms, diagnosis, or treatment of, any disease, disorder, or abnormality of any of the following:

	Yes	No
25. Digestive System		
a. gallbladder, pancreas, or liver?	❑	❑
b. ulcers?	❑	❑
c. gastroesophageal reflux disease (acid reflux, GERD)?	❑	❑
d. rectal bleeding?	❑	❑
e. other digestive system disorder or condition?	❑	❑
26. Urinary System		
a. kidney?	❑	❑
b. other urinary system disorder or condition?	❑	❑
27. Eyes, Ears, Nose		
a. ear or sinus infections (more than two in the past 12 months)?	❑	❑
b. other disorder or condition of the eyes, ears, or nose?	❑	❑
28. Mouth, Throat, or Jaw	❑	❑
29. Skin Disorders	❑	❑
30. Heart or Circulatory System		
a. chest pain?	❑	❑
b. high or low blood pressure?	❑	❑
c. elevated cholesterol?	❑	❑
d. stroke?	❑	❑
e. shunts, stents, or pacemaker?	❑	❑
f. other heart or circulatory system disorder or condition?	❑	❑
31. Male or Female Reproductive System		
a. infertility or erectile dysfunction?	❑	❑
b. sexually transmitted disease?	❑	❑
c. abnormal mammogram or Pap smear?	❑	❑
d. other male or female reproductive system disorder or condition?	❑	❑

	Yes	No
32. Blood, Gland, Endocrine, or Metabolic		
a. thyroid, breast, or other glands?	❑	❑
b. diabetes or sugar in the blood or urine?	❑	❑
c. anemia?	❑	❑
d. immune system disorder (other than AIDS or HIV)?	❑	❑
e. other blood, endocrine, or metabolic disorder or condition?	❑	❑
33. Brain and Nervous System		
a. migraines or chronic or severe headaches?	❑	❑
b. seizures or epilepsy?	❑	❑
c. mental, emotional, or behavioral disorder (including anorexia or bulimia)?	❑	❑
d. multiple sclerosis or paralysis?	❑	❑
e. other brain or nervous system disorder or condition?	❑	❑
34. Muscular or Skeletal System		
a. joints, bones, spine, or back?	❑	❑
b. arthritis or fibromyalgia?	❑	❑
c. amputation?	❑	❑
d. other muscular/skeletal system disorder or condition?	❑	❑
35. Respiratory System		
a. asthma or allergies?	❑	❑
b. sleep apnea?	❑	❑
c. other respiratory system disorder or condition?	❑	❑
36. Cancer, Cyst, or Tumor		
a. cancer?	❑	❑
b. tumor, cyst, polyp, lump, or growth of any kind?	❑	❑
37. Birth Defects or Congenital Abnormalities		
a. Down's syndrome?	❑	❑
b. cerebral palsy?	❑	❑
c. other birth defect or congenital abnormality?	❑	❑

	Yes	No
38. In the last 5 years, has any applicant had any signs, symptoms, diagnosis, or treatment for any other disease, disorder, injury, or condition (excluding childbirth) that is not listed on this application?	❑	❑

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.

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MEDICAL HISTORY DETAILS — FOR ALL APPLICANTS

Question Number: ____________________ Person: ____ Dates: ________________________

Symptoms or Conditions: ____

Prescriptions (include dose, how often taken, dates taken): ____

Treatment, Advice Given, Results, and Other Details: ____

Name, Address, Phone of Doctors, Hospitals, etc.: ____

Question Number: ____________________ Person: ____ Dates: ________________________

Symptoms or Conditions: ____

Prescriptions (include dose, how often taken, dates taken): ____

Treatment, Advice Given, Results, and Other Details: ____

Name, Address, Phone of Doctors, Hospitals, etc.: ____

Question Number: ____________________ Person: ____ Dates: ________________________

Symptoms or Conditions: ____

Prescriptions (include dose, how often taken, dates taken): ____

Treatment, Advice Given, Results, and Other Details: ____

Name, Address, Phone of Doctors, Hospitals, etc.: ____

Question Number: ____________________ Person: ____ Dates: ________________________

Symptoms or Conditions: ____

Prescriptions (include dose, how often taken, dates taken): ____

Treatment, Advice Given, Results, and Other Details: ____

Name, Address, Phone of Doctors, Hospitals, etc.: ____

If you need more space to provide complete and accurate information, please use lined paper, sign and date it, and check this box. ❑

SPECIAL INSTRUCTIONS

This policy is primarily governed by the laws of Illinois. As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida-approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services.

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.

STATEMENT OF UNDERSTANDING — Review the completed application and read the section below carefully before signing.

I personally completed this application. I represent that the answers and statements on it are true, complete, and correctly recorded. **I understand and agree that:**

(1) This application and the initial payment do not give me immediate coverage.
(2) I should not terminate existing coverage until I have accepted the Golden Rule coverage.
(3) Unless Golden Rule agrees to an earlier date, coverage for illness begins on the 15th day after a person becomes insured for injury.
(4) There will be no benefits for any loss incurred in the first year of coverage due to a preexisting condition.
(5) **Incorrect or incomplete information on this application may result in voidance of coverage and claim denial.**
(6) This completed application, and any supplements or amendments, will be a part of any policy/certificate, if issued.
(7) The broker may only submit the application and initial payment, and may not promise me coverage, modify Golden Rule's underwriting policy or terms of coverage, or change or waive any right or requirement.
(8) The broker may receive copies of any correspondence about my medical history when correspondence is required.
(9) **If I continue other coverage existing on the Golden Rule effective date for more than 90 days after that date, the Golden Rule coverage will be void.**
(10) I must notify Golden Rule of any medical conditions or treatment arising between the date of this application and the effective date of my coverage.
(11) I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding all listed dependents.
(12) If Golden Rule rejects this application, under no circumstances will any benefits be payable. Receipt of money, cashing of my check, or charging my credit card by Golden Rule does not constitute approval of my application or create Golden Rule coverage.
(13) Golden Rule may request additional information, and this may delay the processing of this application. If the health care provider charges a fee for these services, Golden Rule will determine its payment, and I will be responsible for any difference.
(14) Golden Rule has the right to rely upon the answers and statements in this application, without requesting medical records from any provider listed.

I have received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

X _____
Primary Applicant (You)

X _____
Parent/Guardian (If you are a minor) Relationship

X _____
Spouse (If to be covered)

_____
Date

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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 13, "Will the term life benefit replace any existing **life** insurance?" (If the response shown for Question 13 does not reflect your understanding, please check this box and attach an explanation. ❑)

X _____
Signature of Licensed Broker

X Joe Santiago
Print Full Name

052561547
Broker Number

FL Agent Number

joe@healthinsoptions.com
Broker E-mail Address

MED-AP-123-09G-GRI

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 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 above: Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.

Signed X _____ at _____ X _____
Date City State Signature of Primary Applicant (You)

X _____ X _____
Signature of Parent/Guardian (If you are a minor) 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 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 _____ X _____
Date City State Signature of Primary Applicant (You)

X _____ X _____
Signature of Parent/Guardian (If you are a minor) Signature of Spouse (If to be covered)

HEALTH SAVINGS ACCOUNT (HSA) APPLICATION (only if opening an HSA with OptumHealth Bank)

By signing below, I acknowledge that:

- I wish to establish an HSA with OptumHealth Bank as custodian.
- I understand and agree that my HSA will be opened under and governed by OptumHealth 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 OptumHealth Bank's Privacy Policy and Schedule of Fees and Charges.
- I authorize OptumHealth Bank to provide information about my HSA, including my account number, to Golden Rule, and those acting on behalf of Golden Rule or OptumHealth 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 OptumHealth 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 OptumHealth 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 authorize OptumHealth to share information about my HSA with the Authorized User named and to allow withdrawals by check, debit card, or other means to be made by such authorized user.
- I certify that the information provided in this application is true and complete.

X _____
Signature of Primary Applicant

Primary Applicant's Social Security Number

Applicant's Spouse Social Security Number

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.

REQUEST FOR AN AUTHORIZED USER DEBIT CARD (OPTIONAL)

Authorized User's _____
First Name Middle Initial

Authorized User's _____
Last Name

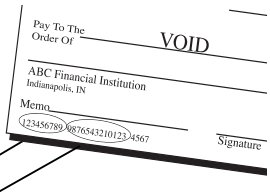
Authorized User's _____
Date of Birth

Authorized User's
Social Security No.

155X-0108

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

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 of its termination from me.



Nine-digit Check Routing No.

Checking Acct. 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.

X _____
Signature of Account Holder

E-mail Address _____

INITIAL PAYMENT CREDIT CARD AUTHORIZATION

I authorize FACT or Golden Rule to bill my MasterCard/Visa 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 Exp. Date: Month Year

Name as Printed on Card: _____

Billing Address City State ZIP

Card Number:

X _____
Signature of Authorized User

May 14 2008 06:26:43 pm

FLORIDA CERTIFICATION

Review the statements and sign where appropriate.

Decide whether or not all of the statements 1-6 apply to you.

1. I do not have any other health insurance coverage (or it will be involuntarily terminated soon).
2. I have been insured by *creditable coverage*[1] (as defined below) for the last 18 months or more with no lapse in coverage of more than 63 days.
3. My most recent coverage was under a *group health plan*[2] (as defined below), a governmental plan, or a church plan; or under an individual plan that terminated due to: the insurer's insolvency; the insurer's discontinuance of all its individual coverage in Florida; or the fact that I no longer live in a Florida service area of my prior insurer's network plan.
4. My most recent coverage was not terminated due to nonpayment of premiums, fraud, or intentional misrepresentations.
5. I am not eligible for any coverage under a conversion plan, a *group health plan*[2] (as defined below), Medicare, or Medicaid.
6. I accepted and exhausted any group continuation of coverage (including COBRA) that was offered to me.

Carefully review the statements above and sign under A. or B.

A. One or more of the six statements above **do not** apply to me.

Signature _____ Date _____

OR

B. I represent that all six of the statements above **do** apply to me.

Signature _____ Date _____

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[1] *Creditable coverage* includes group or individual health insurance coverage, Medicare, Medicaid, Armed Forces coverage, Indian or tribal coverage, state risk pool coverage, public health coverage, and Peace Corps Act coverage. A plan is NOT *creditable coverage* if it: a) provides coverage only for accidents, disability, or liability; b) is credit-only insurance; or c) is secondary to other insurance.

[2] Generally, a *group health plan* is any coverage existing in connection with employment. Included are: employer-sponsored plans (so long as at least one employee participates); coverage of an employee under an individual policy of insurance that is part of a plan, fund, or program established or maintained by an employer that provides medical care to employees or their dependents; coverage of a business owner so long as at least one employee other than the business owner and the business owner's spouse also participates in the plan; and coverage of partners in a plan maintained by the partnership.

879C-0904

THIRD PARTY NOTIFICATION IN CASE OF NONPAYMENT OF PREMIUMS

Under Florida law, you may have the right to designate a secondary addressee to receive an additional notice from Golden Rule regarding life insurance coverage that is about to lapse due to nonpayment of premium when you are 64 or older. You have this right if you: (a) have chosen life insurance coverage to be delivered in Florida; and (b) are not choosing to pay your premiums by monthly preauthorized check (P.A.C.).

If you qualify, please choose one of the following options:

Protection Against Unintended Lapse

❑ I understand that I have the right to designate one person other than myself to receive notice of cancellation of life insurance coverage for nonpayment of premium when I am 64 or older. **I elect NOT** to designate any person to receive such notice.

❑ I would like the following person notified in case of nonpayment of premium when I am 64 or older.

Full Name of Person to Be Notified _____

Home Address _____

City _____ State _____ ZIP Code _____

Applicant's Signature _____ Date _____