

FACT Membership Enrollment Form

Oklahoma

I hereby enroll for Basic \$4 Choice \$20 Elite \$40 membership in the FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS (FACT). Upon completion of this enrollment form and payment of initial dues, I understand that: (a) I will be entitled to FACT's benefits; (b) these benefits may change from time to time; (c) some benefits may have a delayed effective date; (d) my membership will become effective on the day this enrollment form is dated and signed; (e) I am eligible to apply for association group insurance; and (f) I authorize the release of my name, address, date of birth, certificate and phone numbers, application date, membership level, and email address listed on the Golden Rule Insurance Company Application for Insurance to FACT. NOTE: Accident Insurance is included in your FACT membership and you will have an opportunity to name your beneficiary(ies) by mail or on the FACT website.

Member's Signature X _____ Date X _____
 FACT ENFO 1110 If you wish to apply for association group health 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 ID Number _____
 Reinstatement Change deductible _____
 (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 Email Address

e. Payor: _____
 (If not You): Name _____ Email 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

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	Weight
<input type="checkbox"/> Male <input type="checkbox"/> Female	a. Primary (You)						
<input type="checkbox"/> Male <input type="checkbox"/> Female	b. Spouse						
<input type="checkbox"/> Male <input type="checkbox"/> Female	c. Child						
<input type="checkbox"/> Male <input type="checkbox"/> Female	d. Child						
<input type="checkbox"/> Male <input type="checkbox"/> Female	e. Child						
<input type="checkbox"/> Male <input type="checkbox"/> Female	f. Child						
<input type="checkbox"/> Male <input type="checkbox"/> 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. Do all applicants, other than dependent children, read, write, speak, and understand the English language? Yes No

COVERAGE INFORMATION — Must complete for all new applications.

5. Requested Effective Date: ___/___/___

Unless we agree to an earlier date, the effective date will be the later of: (a) the requested effective date, or (b) 30 days after the application is received by Golden Rule. Both injuries and illnesses will have the same effective date.

Plans issued with an effective date less than 30 days after the application received date will include a 14-day wait for illness coverage.

6. All plans include a preferred network. Network Name: _____

7. 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

8. Requested Health Class: Primary: Preferred I Preferred II Standard I Standard II
 Spouse: Preferred I Preferred II Standard I Standard II

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

PRODUCT SELECTION & BILLING (or attach a health insurance quote)

<p><input type="checkbox"/> Copay SelectSM</p> <p><input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000</p> <p>Coinsurance — Out-of-Pocket Maximum After Deductible <input type="checkbox"/> 0% <input type="checkbox"/> 80/20 — \$3,000 <input type="checkbox"/> 70/30 — \$5,000</p> <hr/> <p><input type="checkbox"/> Plan 100[®] <input type="checkbox"/> Plan 80SM <input type="checkbox"/> Saver 80SM</p> <p><input type="checkbox"/> \$1,000 (Saver 80 only) <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000</p> <hr/> <p><input type="checkbox"/> HSA 100[®] <input type="checkbox"/> HSA 70SM</p> <p><input type="checkbox"/> \$1,250 (Single Only) <input type="checkbox"/> \$2,500 (Single and Family) <input type="checkbox"/> \$3,000 (Single Only) <input type="checkbox"/> \$3,500 (Single Only) <input type="checkbox"/> \$5,000 (Single and Family) <input type="checkbox"/> \$6,000 (Family Only) <input type="checkbox"/> \$7,000 (Family Only) <input type="checkbox"/> \$10,000 (Family Only)</p>	<p>FACT Membership Dues (Basic \$4, Choice \$20, Elite \$40): \$ _____</p> <p>Base Premium Amount + _____</p> <p>OPTIONAL BENEFITS — See current brochure for availability</p> <p><input type="checkbox"/> \$25 Office Visit Copay + _____ Optional</p> <p><input type="checkbox"/> 4-Dr. Office Visit Copay - _____ Optional</p> <p><input type="checkbox"/> Prescription Drug — \$200 Deductible + _____ Optional</p> <p><input type="checkbox"/> Prescription Drug — Copay Card + _____ Optional</p> <p><input type="checkbox"/> Prescription Drug — Discount Card Only - _____ Optional</p> <p><input type="checkbox"/> Prescription Drug — Generic Only - _____ Optional</p> <p><input type="checkbox"/> Supplemental Accident:</p> <p><input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 + _____ Optional</p> <p><input type="checkbox"/> Term Life: Primary <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 + _____ Optional</p> <p><input type="checkbox"/> Term Life: Spouse <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 + _____ Optional</p> <p><input type="checkbox"/> Accidental Death: Primary + _____ Optional</p> <p><input type="checkbox"/> Accidental Death: Spouse + _____ Optional</p> <p><input type="checkbox"/> UnitedHealthcare Vision + _____ Optional</p> <p><input type="checkbox"/> Mental Disorders and Substance Abuse + _____ Optional</p> <p><input type="checkbox"/> HSA Deposit + _____ \$25 Monthly Min.</p> <hr/> <p>Total Monthly Payment = \$ _____</p> <p>One-Time HSA Set-Up Fee + _____ \$10</p> <p>Initial Monthly Payment (Payable to "FACT") = \$ _____</p> <hr/> <p>If Quarterly, Total Monthly Payment x 3 = \$ _____</p> <p>One-Time HSA Set-Up Fee + _____ \$10</p> <p>Initial Quarterly Payment (Payable to "FACT") = \$ _____</p>
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10. Initial Payment With Application: Check EFT Credit Card
 Ongoing Payments: Monthly EFT (no billing fee) Direct Bill (\$10 monthly billing fee) List Bill (include forms; \$25 monthly admin. fee per list bill group)
 Quarterly Direct Bill (\$10 quarterly billing fee)

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

Dec 7 2010 05:43:33

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

11. Within the last 63 days, has any applicant been covered by any type of medical insurance? Yes No

 If yes, complete chart below. Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced.

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Is this to be replaced?	Termination Date

12. Will the term life benefit replace any existing life insurance? Yes No

 Company Name _____ Policy Number _____
13. 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: _____
14. Has any applicant previously applied for, or been covered by, Golden Rule or UnitedHealthcare?
 Name _____ Policy/Certificate Number _____

DRIVING — FOR ALL APPLICANTS

15. 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. 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.

16. 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? Yes No
17. In the last 5 years, has any applicant filed a claim and/or received benefits from disability insurance or Worker's Compensation?
18. 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?
19. In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind?
20. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more?
21. 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?
22. 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).

Dec 7 2010 05:43:33

MEDICAL HISTORY — FOR ALL APPLICANTS (continued)

23. In the last 10 years, has any applicant:
- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| a. Had a complicated pregnancy or delivery (including a caesarean section)? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Consulted a health-care provider for any condition or symptom(s) for which a diagnosis has not been established? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Had any signs, symptoms, diagnosis, or treatment of Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness, or tested positive for antibodies to the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had any abnormal physical exam, X-ray, EKG, MRI, CT scan, or any adverse or abnormal laboratory or other test results? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been confined in a hospital for anything other than childbirth? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Had placement, treatment, or maintenance of an internal or external implant or prosthetic device? | <input type="checkbox"/> | <input type="checkbox"/> |

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 | | Yes | No |
| 24. Digestive System | | | 31. Blood, Gland, Endocrine, or Metabolic | | |
| a. gallbladder, pancreas, or liver? | <input type="checkbox"/> | <input type="checkbox"/> | a. thyroid, breast, or other glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. ulcers? | <input type="checkbox"/> | <input type="checkbox"/> | b. diabetes or sugar in the blood or urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. gastroesophageal reflux disease (acid reflux, GERD)? | <input type="checkbox"/> | <input type="checkbox"/> | c. anemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. rectal bleeding? | <input type="checkbox"/> | <input type="checkbox"/> | d. immune system disorder (other than AIDS or HIV)? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. other digestive system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> | e. other blood, endocrine, or metabolic disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Urinary System | | | 32. Brain and Nervous System | | |
| a. kidney? | <input type="checkbox"/> | <input type="checkbox"/> | a. migraines or chronic or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. other urinary system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> | b. seizures or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Eyes, Ears, Nose | | | c. mental, emotional, or behavioral disorder (including anorexia or bulimia)? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. ear or sinus infections (more than two in the past 12 months)? | <input type="checkbox"/> | <input type="checkbox"/> | d. multiple sclerosis or paralysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. other disorder or condition of the eyes, ears, or nose? | <input type="checkbox"/> | <input type="checkbox"/> | e. other brain or nervous system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Mouth, Throat, or Jaw | <input type="checkbox"/> | <input type="checkbox"/> | 33. Muscular or Skeletal System | | |
| 28. Skin Disorders | <input type="checkbox"/> | <input type="checkbox"/> | a. joints, bones, spine, or back? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Heart or Circulatory System | | | b. arthritis or fibromyalgia? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | c. amputation? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. high or low blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | d. other muscular/skeletal system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. elevated cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | 34. Respiratory System | | |
| d. stroke? | <input type="checkbox"/> | <input type="checkbox"/> | a. asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. shunts, stents, or pacemaker? | <input type="checkbox"/> | <input type="checkbox"/> | b. sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. other heart or circulatory system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> | c. other respiratory system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Male or Female Reproductive System | | | 35. Cancer, Cyst, or Tumor | | |
| a. infertility or erectile dysfunction? | <input type="checkbox"/> | <input type="checkbox"/> | a. cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> | b. tumor, cyst, polyp, lump, or growth of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. abnormal mammogram or Pap smear? | <input type="checkbox"/> | <input type="checkbox"/> | 36. Birth Defects or Congenital Abnormalities | | |
| d. other male or female reproductive system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> | a. Down's syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | b. cerebral palsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | c. other birth defect or congenital abnormality? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | Yes | No |
| 37. 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? | <input type="checkbox"/> | <input type="checkbox"/> | | <input type="checkbox"/> | <input type="checkbox"/> |

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.

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

Any person who knowingly and with intent to injure, defraud, or deceive any insurer, makes any claim for the proceeds of an insurance policy containing any false, incomplete, or misleading information is guilty of a felony.

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 (does not apply to applicants under the age of 19).
 - (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

Dec 7 2010 05:43:33

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

By signing to the right, I acknowledge that:

- I wish to establish a health savings account (HSA) with OptumHealth Bank as custodian.
- I understand the eligibility requirements for deposits made to my HSA and state that I qualify to make deposits to this account. I have reviewed this application and understand and agree that my HSA will be opened under and governed by OptumHealth Bank's Custodial and Deposit Agreement and that the terms and conditions therein will be binding on me. This document will be sent to me when my account is opened, along with OptumHealth Bank's Privacy Policy and Schedule of Fees.
- 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, may provide information on my behalf to establish and maintain my HSA and authorize Golden Rule and its designee to take such action deemed necessary and appropriate by Golden Rule to administer my HSA, including but not limited to, making deposits and correcting errors where necessary.
- 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.
- I have requested a MasterCard Prepaid Debit Card and if I have filled out the information to request an Authorized User 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 Bank to share information about my HSA with the Authorized User named and to allow any account transactions 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

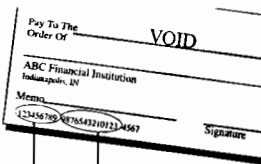
Authorized User's _____
Date of Birth

Authorized User's _____
Social Security No.

155X-1108

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 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. _____

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 _____
Authorized Account Signature

Email 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

Card Number: _____

X _____
Signature of Authorized User

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

IMPORTANT INFORMATION

Before You Submit Your Application:

- If you were previously insured by UnitedHealthcare or any of its companies, you still must complete this application fully and accurately.
- Read the applicable product brochure(s).
- Altered applications will not be accepted.
- Brokers must be licensed with Golden Rule in the state where an application is signed and the state where the primary applicant resides.
- Coverage is not available if:**
 - Any family member, whether or not named in this application, is currently pregnant; or
 - The applicant has not resided in the U.S. for at least 12 consecutive months.

Important Information:

- Any person who knowingly presents false, incomplete, or misleading information in an application for insurance may be committing insurance fraud.
- You must disclose your full health history and the full health history of all applicants listed on the application. Even if your application is approved, any omissions or false statements may result in future claims being denied and/or termination or rescission of coverage.
- Include all requested details and explanations. If you need to include additional information, attach an extra sheet of paper. Include your signature and date on the extra sheet.
- Do not cancel any existing coverage you might have until you are notified that your application has been approved.