Please Print in Black Ink

APPLICATION FOR SHORT TERM MEDICAL℠ INSURANCE
GOLDEN RULE INSURANCE COMPANY — INDIANAPOLIS, INDIANA 46278-1719

No application will be accepted if received by Golden Rule more than 15 days after the date signed.

ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

PROPOSED INSURED

First | Middle Initial | Last | Social Security No. | Height | Weight | Birth Date * | Age | ☐ Male ☐ Female

RESIDENT ADDRESS **PO Boxes are not accepted.**

Street (Include Apt.) | City | State | ZIP | ( ) Telephone No.

1. List below any dependents to be covered under the policy/certificate.

Dependent's Name (Last, First, M.I.)	Social Security Number	Relationship	Height	Weight	Date of Birth*	
		Spouse			/ /	☐ M ☐ F
	N/A				/ /	☐ M ☐ F
	N/A				/ /	☐ M ☐ F
	N/A				/ /	☐ M ☐ F
	N/A				/ /	☐ M ☐ F
	N/A				/ /	☐ M ☐ F

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

		Yes	No
2.	Are you or is any family member (whether or not named in this application) an expectant mother or father, in the process of adopting a child, or undergoing infertility treatment?..... **If yes, coverage cannot be issued.**	☐	☐
3.	Have you or has anyone named in Question 1 been declined for insurance due to health reasons?..... If yes, long-form application MED-AP-123-42-GRI2 must be used. For effective date, see long-form application.	☐	☐
4.	Have you or has 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? If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy/certificate.)	☐	☐
5.	Do you or does any person named in Question 1 now have hospital or medical expense insurance that **will not** terminate..... prior to the requested effective date? If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy/certificate.)	☐	☐
6.	Within the last 5 years, have you or has anyone listed on the application received medical or surgical consultation, advice, or treatment, including medication, for **any of the following:** liver disorders, kidney disorders, chronic obstructive pulmonary disorder (COPD) or emphysema, diabetes, cancer, heart or circulatory system disorders (excluding high blood pressure), Crohn's disease or ulcerative colitis, or alcohol or drug abuse? ..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy/certificate.)	☐	☐
7.	Within the last 5 years, have you or anyone listed on the application been diagnosed with or treated for immune system disorder by a doctor or other licensed clinical professional, including HIV infection, or had a positive test for HIV infection performed by a doctor or other licensed clinical professional?..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy/certificate.)	☐	☐

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

PLAN: ☐ **Short Term Medical℠ Plus Elite** ☐ **Short Term Medical℠ Copay** ☐ **Short Term Medical℠ Copay Value**
☐ **80/20 - $2,000** **70/30 - $10,000** **70/30 - $10,000**
☐ **70/30 - $5,000**
☐ **Short Term Medical℠ Plus** ☐ **Short Term Medical℠ Value**
☐ **80/20 - $2,000** ☐ **70/30 - $5,000**
☐ **70/30 - $5,000** ☐ **70/30 - $10,000**

REQUESTED EFFECTIVE DATE:
_____/_____/_____
(See Statement of Understanding section.)

DEDUCTIBLE: ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $10,000

DAYS OF COVERAGE: _____ (30-360 Days)

OPTIONAL BENEFITS:
☐ Supplemental Accident Benefit ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $10,000
☐ Per Cause Deductible

PRESCRIPTION DRUGS *(You may only choose one.)*:
☐ Prescription Drug - Add 4 Tier Rx Coverage *(Available with Short Term Medical℠ Copay Plan only)*
☐ Prescription Drug - Add a Generic $20 Rx Copay *(Available with all Plans except Short Term Medical℠ Value)*
☐ Prescription Drug - Remove Rx Coverage *(Available with Short Term Medical℠ Copay Plan only)*
☐ Prescription Drug - Add Rx Coverage *(Available with Short Term Medical℠ Copay Value Plan only)*

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 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. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy/certificate that may be issued. I understand that for an application sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after receipt by Golden Rule. I understand that for a mailed application, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after the postmark date affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (i) the requested effective date; or (ii) the date received by Golden Rule. I understand that the broker is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

X _____ X _____
Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child — Date you signed and read application

_____ _____
Licensed Agent or Broker (Please Print) — Individual Producer #

STM-AP-152-GRI-42

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 Basic ($4 a month) 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 Application for Short Term Medical 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.

X _____ _____
Member's Signature — Date

Email Address: _____

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

FACT ENFO STM 1213

ADDITIONAL ADDRESS INFORMATION (Complete if Mailing Address is different than Resident Address listed on page 1.)

Mailing Address
Street (Include Apt.)
City State ZIP

PAYMENT OPTIONS: SINGLE OR MONTHLY (Initial Payment Method Required With Application)

Electronic Funds Transfer (EFT) and Credit Card payments will be collected on the date we issue coverage, or the effective date of the policy, whichever is later.
If Initial Payment is EFT, Ongoing Payment must be EFT.

If you choose Check as your Initial Payment Method, please mail your check with your completed application - checks are deposited upon receipt.

☐ **Single Payment** (one single payment for all days of coverage chosen/lump sum):

- ☐ **EFT $ Amount** _____ Includes $20 nonrefundable application fee.
  For this method of payment, you must complete the EFT Authorization below.
- ☐ **Credit card $ Amount** _____ (Total Single Payment. Includes $20 nonrefundable application fee.)
  For this method of payment, you must complete the Credit Card Authorization below.
- ☐ **Check or money order $ Amount** _____ Includes $20 nonrefundable application fee.
  For this method of payment, you must make check or money order payable to FACT.

OR

☐ **Monthly Payment:** (Based on 30 days of coverage) Final Premium Payment may be less due to less than 30 days of coverage remaining.

Initial Payment ☐ EFT ☐ Credit Card ☐ Check or money order (For this method of payment, you must make check or money order payable to FACT.)

$ Amount _____ First month amount (shown) includes a one-time $20 nonrefundable application fee.

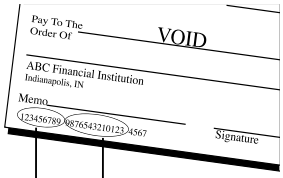
Ongoing Payments (Choose one)

- ☐ **Direct Bill** ($10 monthly billing fee.)
  Additional monthly Direct Bill payments will not include the $20 application fee, however they will include a $10 monthly billing fee.
- ☐ **Electronic Funds Transfer** (EFT) (No billing fee.)
  Additional monthly EFT payments will not include the $20 application fee.
- ☐ **Credit Card** (No billing fee.)
  Additional monthly Credit Card payments will not include the $20 application fee.

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION — COMPLETE 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)

X _____
Authorized Account Signature

Email Address _____

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.

CREDIT CARD AUTHORIZATION — COMPLETE ONLY IF PAYING BY CREDIT CARD

Credit Card Authorization ☐ Visa ☐ MasterCard ☐ American Express

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

Account No. _____ Expiration Date _____ Billing ZIP Code _____ X _____
Signature of Authorized User

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

Charge On _____
Day

Only select a charge date between the 1st and 28th of the month.

PAYOR INFORMATION (If other than Proposed Insured)

Payor: _____
Name Email Address

_____
Street City State ZIP

Mar 16 2016 11:52:32 am