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 ❑ Reinstatement ❑ Add a spouse Policy Number ______ (for additions, reinstatements)

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 time to call Email Address

e. Payor (If not You): ______
Name Email Address
______
Street City State ZIP

f. Your Beneficiary: ______
Name Relationship Age

You will be the beneficiary for your spouse.

g. Your Occupation: ______

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

Gender	Name (Last, First, M.I.)	Birth Date	Age	Height	Weight
❑ Male ❑ Female	a. Primary (You)				
❑ Male ❑ Female	b. Spouse				

COVERAGE INFORMATION — Must complete this for all new applications.

4. Requested Effective Date: __ __/__ __ / __ __ __ __

AVAILABLE PRODUCTS

5. **Please select only one plan.**

PLAN SELECTION

Critical Illness

❑ $10,000 ❑ $20,000 ❑ $30,000 ❑ $40,000 ❑ $50,000

BILLING (or attach a health quote printout)

6. **Initial Payment With Application:** ❑ Check ❑ EFT ❑ Credit Card

   Initial Monthly Payment (Payable to Golden Rule) **= $** ____________

   Ongoing Payments: ❑ Monthly (EFT) ❑ Annual Direct Bill

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

UNDERWRITING QUESTIONS: Must be completed for all new applications and reinstatements. For adding a spouse, complete this only for the spouse.

	Question	Primary (You)	Spouse
7.	Do you or your spouse have or are currently applying for other critical illness or lump sum benefit coverage for cancer or other specified conditions?	❑ Yes ❑ No	❑ Yes ❑ No
	$ ________ Primary Amount; Name of Company ________ $ ________ Spouse Amount; Name of Company ________		
8.	Have you or your spouse been previously declined for critical illness or lump sum benefit insurance for cancer or other specified conditions? Provide date and reason for decline: ________	❑ Yes ❑ No	❑ Yes ❑ No
9.	Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months?	❑ Yes ❑ No	❑ Yes ❑ No
10.	**During the past 24 months, have you or your spouse:**		
	a. Consulted a health care provider for any condition or symptom(s) for which a diagnosis has not been established?	❑ Yes ❑ No	❑ Yes ❑ No
	b. Been advised to undergo any treatment, hospitalization, or surgery which has not yet been completed?	❑ Yes ❑ No	❑ Yes ❑ No
11.	**In the last 10 years, have you or your spouse been diagnosed with or received medical care from a member of the medical profession for any of the following:**		
	a. Heart attack, Cardiomyopathy, bypass/stents/angioplasty, atrial fibrillation, implant of pacemaker/defibrillator, heart surgery (including valve replacement or correction), congestive heart failure?	❑ Yes ❑ No	❑ Yes ❑ No
	b. Stroke/transient ischemic attack?	❑ Yes ❑ No	❑ Yes ❑ No
	c. Chronic Obstructive Pulmonary Disease (COPD) or chronic lung disease, Emphysema, Sarcoidosis, pulmonary fibrosis?	❑ Yes ❑ No	❑ Yes ❑ No
	d. Diabetes (except gestational diabetes) organ transplant (or awaiting an organ transplant), kidney disease or disorder (not including stones), liver disease or disorder (excluding Hepatitis A), Hepatitis B or C?	❑ Yes ❑ No	❑ Yes ❑ No
	e. Acquired AIDS, ARC, HIV infection or any AIDS related condition?	❑ Yes ❑ No	❑ Yes ❑ No
	f. Any cancer (other than a single occurrence of skin cancer), Carcinoma in Situ, Leukemia, Hodgkin's or Non-Hodgkin's Lymphoma, Alzheimer's or senile dementia?	❑ Yes ❑ No	❑ Yes ❑ No
	g. Paralysis, Multiple Sclerosis, Muscular Dystrophy, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease)?	❑ Yes ❑ No	❑ Yes ❑ No
	h. Glaucoma or macular degeneration?	❑ Yes ❑ No	❑ Yes ❑ No
	i. Cochlear implants or Meniere's Disease?	❑ Yes ❑ No	❑ Yes ❑ No
12.	**During the past 24 months, have you or your spouse been diagnosed with, received medical care from a member of the medical profession for, or experienced symptoms of any of the following:**		
	a. Unexplained weight loss, unexplained fatigue, unexplained dizziness?	❑ Yes ❑ No	❑ Yes ❑ No
	b. Recurrent breast tumors, or unexplained tumors/growths, abnormal pap smear without normal follow-up pap smear?	❑ Yes ❑ No	❑ Yes ❑ No
	c. Disorder of the heart or circulatory system, vascular insufficiency (circulatory problems), pulmonary hypertension, chest pains, irregular heart beat, Tachycardia?	❑ Yes ❑ No	❑ Yes ❑ No
	d. Recurrent Human Papillomavirus (HPV)?	❑ Yes ❑ No	❑ Yes ❑ No
	e. Systemic Lupus Erythematosus (SLE), Cystic Fibrosis?	❑ Yes ❑ No	❑ Yes ❑ No
	f. Alcohol abuse, drug abuse?	❑ Yes ❑ No	❑ Yes ❑ No
	g. Any disease or disorder which has led or may lead to a permanent or progressive loss of vision, hearing, or speech?	❑ Yes ❑ No	❑ Yes ❑ No

If the primary applicant answers "yes" to any underwriting questions (#10-12) above, a policy will not be issued. If the spouse answers "yes" to any underwriting questions (#10-12) above, the spouse will not be covered under the policy.

SPECIAL INSTRUCTIONS

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) There will be no benefits for any loss incurred in the first 12 months of coverage due to a preexisting condition.

(3) **Incorrect or incomplete information on this application may result in voidance of coverage and/or claim denial.**

(4) This completed application, and any supplements or amendments, will be a part of any policy/certificate, if issued.

(5) 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.

(6) The broker may receive copies of any correspondence about my medical history when correspondence is required.

(7) 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.

(8) 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 applicants.

(9) 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.

(10) 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.

(11) Golden Rule has the right to rely upon the answers and statements in this application, without requesting medical records from any provider.

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

X ______________________________ ____/____/____
Primary Applicant (You) Date

X ______________________________ ____/____/____
Spouse (If to be covered) Date

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.

X ______________________________ Signature of Licensed Broker

X ______________________________ Print Full Name

Broker Number

AUTHORIZATION TO OBTAIN AND DISCLOSE NONMEDICAL INFORMATION

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 MIB, Inc., formerly known as 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.

ANI-0311

I have read the above: Authorization to Obtain and Disclose Nonmedical Information.

Signed X ____/____/____ Date

X ______________________________ Signature of Primary Applicant (You)

X ______________________________ Signature of Spouse (If to be covered)

40447-G-0311

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, MIB, Inc., formerly known as 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 ____/____/____ Date

X ______________________________ Signature of Primary Applicant (You)

X ______________________________ Signature of Spouse (If to be covered)

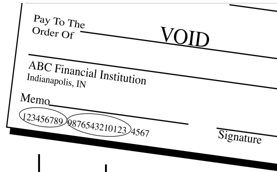
40448-G-0311

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

I (we) hereby authorize Golden Rule or UnitedHealthcare 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 first day of each month ______
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 Golden Rule or UnitedHealthcare to bill my MasterCard/Visa account for the Initial Payment.

Card Number: ______

Type of Card: ❑ MasterCard ❑ Visa Exp. Date: ______ ______
Month Year

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.

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.

SUBMITTING YOUR COMPLETED APPLICATION

- Review your application to be sure it is completed.
- Sign and date your application and related forms. Signature is also required for your spouse if your spouse is to be covered.
- **Applications received by Golden Rule more than 15 days after the signed date will not be accepted.**
- **Mail the Application and Related Forms and be sure to include the following:**
  – Initial payment:
    Check made payable to "Golden Rule";
    EFT authorization (if paying via EFT); or
    Credit card authorization (if paying via credit card).

Mail to: Golden Rule Insurance Company
ATTN: NEW BUSINESS
PO Box 19032
Green Bay, WI 54307-9032

Please Note:

- You will be notified of the actions taken within 45 days after the date of application, or be given the reason for delay.
- There is no coverage until approved in writing by Golden Rule.

TO BE COMPLETED BY BROKER ONLY IF PERSONALLY COLLECTING INITIAL PREMIUM PAYMENT.

CONDITIONAL RECEIPT FOR Critical Illness **THIS FORM LIMITS OUR LIABILITY.**

Proposed Insured: ______________________

Amount Received: ______________________ Date of Receipt: ______________________

NO INSURANCE WILL BECOME EFFECTIVE UNLESS ALL FIVE CONDITIONS PRIOR TO COVERAGE ARE MET. NO PERSON IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS. YOUR CANCELLED CHECK WILL BE YOUR RECEIPT.

THIS CONDITIONAL RECEIPT DOES NOT CREATE ANY TEMPORARY OR INTERIM INSURANCE AND DOES NOT PROVIDE ANY COVERAGE EXCEPT AS EXPRESSLY PROVIDED IN THE CONDITIONS PRIOR TO COVERAGE.

Signature of Secretary

____

Signature of Agent/Broker

CONDITIONS PRIOR TO COVERAGE (APPLICABLE WITH OR WITHOUT THE CONDITIONAL RECEIPT)

Subject to the limitations shown below, insurance will become effective if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Golden Rule Insurance Company (Golden Rule).
2. All medical examinations, if required, have been satisfactorily completed.
3. The persons proposed for insurance must be, on the effective date, not less than a standard risk acceptable to Golden Rule according to its regular underwriting rules and standards for the exact plan and amount of insurance applied for.
4. The first full premium, according to the mode of premium payment chosen, has been paid on or prior to the effective date, and any check is honored on first presentation for payment.
5. The policy is: (a) issued by Golden Rule exactly as applied for within 45 days from date of application; (b) delivered to the proposed insured; and (c) accepted by the proposed insured.

Definitions:

1. "Satisfactorily completed" means that no adverse medical conditions or abnormal findings have been detected which would lead Golden Rule to decline issuing the policy or to issue a specially ridered policy.

Limitation:

If, for any reason, Golden Rule declines to issue a policy or issues a policy other than a standard policy as applied for, Golden Rule shall incur no liability under this receipt except to return any premium amount received. Interest will not be paid on premium refunds.

KEEP THIS DOCUMENT. IT HAS IMPORTANT INFORMATION.

Copyright © 2011 Golden Rule Insurance Company, the underwriter of these plans marketed under the UnitedHealthOne brand.