Please Print
in Black Ink

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

ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

PROPOSED INSURED _____ (First / Middle Initial / Last) _____/_____/_____* (Birth Date) _____ (Age) ☐ Male ☐ Female (Sex)

RESIDENT ADDRESS _____ (Street / City / State / Zip) ( ) _____ (Telephone No.)

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

Dependent's First Name	Relationship to You	Date of Birth*	Dependent's First Name	Relationship to You	Date of Birth*
	Spouse	/ /			/ /
		/ /			/ /
		/ /			/ /

*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? **If yes, coverage cannot be issued.**	☐	☐
3.	Have you or anyone named above been declined for insurance due to health reasons? If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy/certificate.)	☐	☐
4.	Have you or 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 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 anyone listed on the application received medical or surgical consultation, advice, or treatment, including medication, for **any of the following:** liver disorders, kidney disorders, emphysema, diabetes, cancer, heart or circulatory system disorders (including high blood pressure), alcohol or drug abuse or immune system disorders, including HIV infection, or tested positive for HIV infection? If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy/certificate.)	☐	☐

DEDUCTIBLE: ☐ $ 250 ☐ $ 500 ☐ $1,000 ☐ $1,500 **REQUESTED EFFECTIVE DATE:** _____/_____/_____ (See Statement of Understanding section below.)

PAYMENT OPTION: ☐ SINGLE ☐ MONTHLY

COINSURANCE: ☐ 80/20 to $5,000 ☐ 50/50 to $5,000

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 Home 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. 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 which 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 at its Home Office. 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 _____ Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child

X _____ State where you signed this application

X _____ Date you signed and read application

_____ Licensed Agent or Broker (Please Print)

_____ Individual Producer #

Notice: The state of Pennsylvania requires that we provide you with the following information: Any person who knowingly and with intent to defraud any insurance company or other person files an application for insurance or statement of claim containing any materially false information or conceals, for the purpose of misleading, information concerning any fact material thereto commits a fraudulent insurance act, which is a crime and subjects such person to criminal and civil penalties.

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

Note: P.O. Boxes are not accepted for the Resident Address.

To Continue Your Application for Coverage, You Must Become A Member Of FACT

Read and fill out the following FACT Membership Enrollment Form.

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 this application to FACT.

X _____ X _____

Member's Signature Date

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

FACT ENFO 0402

Payment Options: *choose one*

☐ **Single Payment: Check or money order**

For this Single Payment method of payment, you must make check or money order payable to FACT.

☐ **Single Payment: Credit card**

For this Single Payment 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 Premium and FACT Dues.

_____ _____/_____/_____

Account No. Expiration Date

X _____

Signature

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

☐ **Monthly Payment: Preauthorized Charge (P.A.C.)**

For this Monthly Payment method of payment, you must complete the Preauthorized Charge (P.A.C.) Authorization below.

Preauthorized Charge (P.A.C.) Authorization

I hereby authorize Golden Rule Insurance Company 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 from me of its termination.

Financial Institution

Name _____ Address _____

City _____ State _____ Zip _____

Draft On _____ of each month

Day

X _____ X _____

Printed Name of Financial Institution Depositor

Signature of Financial Institution Depositor
As shown on the account to which this authorization is applicable

_____/_____/_____

Date

IMPORTANT: BE SURE TO INCLUDE A VOIDED BLANK CHECK OR A BLANK DEPOSIT SLIP FOR YOUR CHECKING ACCOUNT WITH THIS AUTHORIZATION.