

Golden Rule Health Insurance and Health Savings Account (HSA) Application – Illinois

Download / Print the application form, then complete it by hand.

In completing the application form, pay particular attention to the following items:

- Use black ink. Do not use pencil. Do not type on the application form.
- Complete the FACT MEMBERSHIP ENROLLMENT FORM at the top of Page 1. FACT membership is a necessary condition of Golden Rule medical coverage.
- **Coverage Information** – Page 2: Indicate your Requested Effective date. You don't need to check one of the "Requested Health Class" categories, as your answers to various application questions will determine the "Health Class" assigned to you. Also, you do not need to fill in the blank for "Network Name."
- **Billing** – Page 2: Specify how you intend to pay for coverage: Monthly or Quarterly. If you prefer to pay monthly, your payments are automatically transferred from a bank account you designate. You'll need to complete the "MONTHLY P.A.C. AUTHORIZATION" form at the top of Page 5. You'll also need to provide a voided check from your designated bank account.

Golden Rule also provides the option of charging your initial payment to a Visa or Mastercard. You can provide corresponding credit card information in the "BILLING" section on page 2.

- **Medical History** – Page 3: Answer each medical question (18 through 33) "yes" or "no." If "yes," provide corresponding details where indicated on Page 4. It is very important that you provide complete details regarding any "yes" responses. Incomplete information will delay processing of your application.

After the medical questions, provide initials and date where indicated at the bottom of page 3.

- On Page 4 you must provide signature(s) in the Section titled "STATEMENT OF UNDERSTANDING."
- On Page 5 you must provide signature(s) in the Sections titled "HEALTH INSURANCE CERTIFICATION ..." and "AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION."
- If you're applying for HSA-compatible health insurance and you want Golden Rule / Exante Bank to be the administrator of your HSA, complete the "HEALTH SAVINGS ACCOUNT (HSA) APPLICATION" section on Page 6.

A payment must accompany your application. Provide a one-month payment if you choose the "Monthly P.A.C." billing option. Provide a three-month payment if you choose the Quarterly billing option. Be sure to include payment for all premiums dues and HSA deposits and fees (if applicable).

Return the completed application and check payable to "FACT" to the following address:

**MedPlan Access
6 Grapevine Place
P.O. Box 2220
West Lafayette IN 47906**

- **Applications cannot be processed without payment. Your check must be payable to "FACT."**

I will be pleased to review the plan and application with you. Just call me.

Approval of applications generally takes two to six weeks following submission to Golden Rule. The key factors in this process are 1) the completeness of your submitted application, 2) whether Golden Rule requires copies of medical records and 3) how long it takes a physician or hospital to respond to Golden Rule's request (should a request be made) for medical records.

Joe Risse
MedPlan Access
1-877-MedPlan (1-877-633-7526)

Proceed to Application



FACT 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 the Golden Rule Insurance Company Application for Insurance to FACT.

Member's Signature X _____ Date X _____

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

FACT ENFO 0105

**GOLDEN RULE INSURANCE COMPANY
APPLICATION FOR INSURANCE**

To be filled out personally by the applicant(s)

PLEASE PRINT IN BLACK INK

Do not separate application pages

APPLICANT(S) INFORMATION (Only list persons applying for coverage)

Name (Last, First, M.I.)	Marital Status	Social Security Number	Birth Date	Age	Sex	Height	Weight
1. Primary (You)	<input type="checkbox"/> M <input type="checkbox"/> S						
2. Spouse							
3. Dependent Children Name (Last, First, M.I.)			Birth Date	Age	Sex	Height	Weight
a.	Not Required						
b.							
c.							
d.							
e.							

4. Primary Applicant's Address (P.O. Boxes are not accepted.)
 _____ Street _____ City _____ State _____ ZIP _____

5. Phone Numbers: () ()
 Home Other Best number and time to call E-mail Address

6. Payor (If not You): Name _____ Street _____ City _____ State _____ ZIP _____

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

8. Your Occupation: _____ Date Hired: _____ 9. Total Annual Household Income: \$15,000 or less \$35,001 to \$50,000 \$75,001 to \$99,999
 Prior Employment (If within 2 years): _____ \$15,001 to \$35,000 \$50,001 to \$75,000 \$100,000 or more

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

COVERAGE INFORMATION

11. Requested Effective Date: ___/___/___ Requested Health Class: Primary: Preferred Standard Tobacco (if question 32 is yes)
 Plan includes Preferred Network; if not wanted, check here Spouse: Preferred Standard Tobacco (if question 32 is yes)
 Network Name: _____

Copay Plans	<input type="checkbox"/> Copay Select SM <input type="checkbox"/> \$ 500	HSA Plans	Single <input type="checkbox"/> HSA 100 [®] <input type="checkbox"/> \$1,050	Family <input type="checkbox"/> \$ 2,100	High Deductible	<input type="checkbox"/> \$ 500 (Saver 80 only)
	<input type="checkbox"/> \$1,000		<input type="checkbox"/> HSA Saver [®] <input type="checkbox"/> \$1,800	<input type="checkbox"/> \$ 3,650		<input type="checkbox"/> Plan 100 [®] <input type="checkbox"/> \$1,000 (Saver 80 only)
	<input type="checkbox"/> \$1,500		<input type="checkbox"/> \$2,700	<input type="checkbox"/> \$ 5,450		<input type="checkbox"/> Plan 80 SM <input type="checkbox"/> \$1,500 (Saver 80 only)
	<input type="checkbox"/> \$2,500		<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$ 7,500		<input type="checkbox"/> Saver 80 SM <input type="checkbox"/> \$2,500
	<input type="checkbox"/> Copay Saver SM <input type="checkbox"/> \$2,000		<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000		<input type="checkbox"/> \$3,500
						<input type="checkbox"/> \$5,000
Optional	<input type="checkbox"/> Term Life Benefit	Optional	<input type="checkbox"/> Term Life Benefit	Optional		<input type="checkbox"/> Term Life Benefit <input type="checkbox"/> Preventive Care
	<input type="checkbox"/> Preventive Care (Not Available with Copay Select)		<input type="checkbox"/> Preventive Care			<input type="checkbox"/> Supplemental Accident
	<input type="checkbox"/> Supplemental Accident		<input type="checkbox"/> Hospital Indemnity Rider			<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 Maximum Maternity
	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 Maximum Maternity					<input type="checkbox"/> Prescription Drug Card (Not Available with Saver 80)

BILLING (or attach health insurance quote)

12. Initial Payment With Application
 Check P.A.C. (EFT with on-line app. only) Credit Card →

Ongoing Payments
 Monthly P.A.C. (EFT) Quarterly Direct Bill List Bill (include forms)

FACT Dues \$ 3.00

Base Premium Amount + _____

Term Life Benefit + _____ Optional

Preventive Care + _____ Optional

Supplemental Accident + _____ Optional

Maternity Benefit + _____ Optional

Prescription Drug Card + _____ Optional

HSA Deposit + _____ \$25 Monthly Minimum (only with HSA)

Total Monthly Payment = \$ _____ → **If Quarterly** → **X3 = \$ _____** **Total Quarterly Payment**

One-Time HSA Set-Up Fee + _____ \$10 only with HSA + _____ One-Time HSA Set-Up Fee

One-Time HSA Indemnity Rider + _____ + _____ One-Time HSA Indemnity Rider

Initial Payment = \$ _____ Make check payable to "FACT:" = \$ _____ **Initial Payment** ←

Initial Payment Credit Card Authorization

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

Security Code _____ (last 3 digits in signature line)

Name as Printed on Card _____

Billing Address _____ City _____ State _____ ZIP _____

Card Number _____

X _____
 Signature of Authorized User

OTHER COVERAGE

13. Within the last 62 days, has any applicant **been covered by** any type of **medical** insurance? If yes, complete chart below. Yes No
Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced (see (7) 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

14. Will the term life benefit replace any existing **life** insurance? Company Name _____ Policy # _____ Yes No

15. Has any applicant ever had an application or policy, voided, declined, postponed, rated, or charged an extra premium, or had coverage modified (including medical exclusion riders) by any health or life insurer? (If yes, list name and give details.) Yes No
 Person: _____ Company: _____ Action Taken: _____
 Date: _____ Reason for Action: _____

16. Has any applicant previously applied for, or been covered by, Golden Rule? Yes No
 If yes, who? _____ Policy/Certificate # _____

DRIVING

- Yes No
17. In the last 24 months, has any applicant participated in driving any type of motorcycle?
- If yes, please answer the following questions:**
- a. Name of applicant(s)? _____
- b. Does the applicant have a valid motorcycle license?
- c. Within the last 24 months, has the applicant had his/her license suspended or revoked?
- d. Within the last 24 months, has the applicant, while operating a 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! PLEASE PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS."

- | | Yes | No | | Yes | No |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 18. Is any family member (whether or not named in this application) pregnant or an expectant mother or father? | <input type="checkbox"/> | <input type="checkbox"/> | 25. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the: | | |
| 19. Do any applicants, other than dependent children, not read, write, speak, and understand the English language? | <input type="checkbox"/> | <input type="checkbox"/> | a. heart or circulatory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have an adoption pending? | <input type="checkbox"/> | <input type="checkbox"/> | b. nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. In the last 6 months , has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind? | <input type="checkbox"/> | <input type="checkbox"/> | c. digestive system? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the: | | | d. muscular or skeletal system? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> | e. respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. pancreas or liver? | <input type="checkbox"/> | <input type="checkbox"/> | f. male or female reproductive system, including infertility? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. joints or spine? | <input type="checkbox"/> | <input type="checkbox"/> | g. urinary system? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. kidney? | <input type="checkbox"/> | <input type="checkbox"/> | h. thyroid, breast, or other glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. eyes, ears, or nose? | <input type="checkbox"/> | <input type="checkbox"/> | 26. In the last 10 years, has any applicant had any diagnosis or treatment by a physician for Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. mouth, throat, or jaw? | <input type="checkbox"/> | <input type="checkbox"/> | 27. In the last 10 years, has any applicant had a persistent, recurrent fever greater than 100 degrees Fahrenheit for 3 weeks or more, unexplained chronic fatigue for one month or more, night sweats for one month or more, or a chronic cough for one month or more? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of: | | | 28. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any other disease, disorder, injury, or adverse finding, or had any adverse or abnormal test results? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | 29. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | 30. In the last 5 years, has any applicant had any indication, diagnosis, or treatment of an alcohol or drug dependency, problem, or abuse; or any alcohol- or drug-related arrest? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 31. Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks per week? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. paralysis? | <input type="checkbox"/> | <input type="checkbox"/> | 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; 1 oz. of hard liquor). | | |
| e. arthritis? | <input type="checkbox"/> | <input type="checkbox"/> | 32. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, mark "Tobacco" in Question 11.) | <input type="checkbox"/> | <input type="checkbox"/> |
| f. convulsions or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> | 33. 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. | | |
| g. elevated cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| h. sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| i. cancer? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| j. diabetes or sugar in the blood or urine? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| k. stroke? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| l. tumor, cyst, polyp, lump, or growth of any kind? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| m. mental, emotional, or behavioral disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| 24. In the last 10 years, has any applicant: | | | | | |
| a. had a complicated pregnancy or delivery? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| b. tested positive for antibodies to the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| c. been hospital confined, had surgery, or discussed surgery? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

MONTHLY P.A.C. AUTHORIZATION -- ONLY IF PAYING BY MONTHLY P.A.C.

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 from me (or either of us) of its termination.

Routing No. _____

Checking Account No. _____

Include Voided BLANK check!

Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____ Day _____ (Date Signed)

X _____
(Signature of Account Holder)

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 person,

employer, insurance company, consumer-reporting agency, or the Medical Information Bureau (MIB) having nonmedical information about 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 _____ City _____ State

X _____
Signature of Primary Applicant (You)

X _____
Signature of Parent/Guardian (If You are a minor)

X _____
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, 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 have read the above: Authorization to Obtain and Disclose Health Information.

Signed X _____ / _____ / _____ at _____ City _____ State

X _____
Signature of Primary Applicant (You)

X _____
Signature of Parent/Guardian (If You are a minor)

X _____
Signature of Spouse (If to be covered)

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 14, "Will the term life benefit replace any existing life insurance?" (If the response shown for Question 14 does not reflect your understanding, please check this box and attach an explanation.)

X _____
Signature of Licensed Broker

X _____
Print Full Name

1484711

Broker Number

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

By signing below, I acknowledge that:

- I wish to establish an HSA with Exante Bank as custodian.
- I understand and agree that my HSA will be opened under and governed by Exante 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 Exante Bank's Privacy Policy and Schedule of Fees and Charges.
- I authorize Exante Bank to provide information about my HSA, including my account number, to Golden Rule, and those acting on behalf of Golden Rule or Exante 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 Exante 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 Exante 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 certify that the information provided in this application is true and complete.

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.

Have you, within the last 6 months, been covered under another health insurance plan? Yes No
Has your spouse? Yes No

REQUEST FOR AN ADDITIONAL 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.

X _____
Signature of Primary Applicant
Primary Applicant's
Social Security Number _____

155X-0606

REVIEW BEFORE MAILING THE APPLICATION

Be sure:

- To read the current product brochure before completing the application for insurance.

Note:

- If you were previously insured by UnitedHealthcare, you must still fully complete this application accurately. Our underwriters do not have access to UnitedHealthcare underwriting and claims files.
- Broker must be licensed with Golden Rule in state where application is signed AND state where applicant resides.
- Coverage is not available if:
 - any family member is currently pregnant; or
 - the applicant has not resided in the U.S. for the last 12 consecutive months.
- Altered applications will not be accepted.
- Any person who knowingly presents false, incomplete, or misleading information in an application for insurance may be committing insurance fraud.

- The applicant will be notified of the actions taken within 45 days after the date of the application, or be given the reason for delay.
- There is no coverage until approved in writing by Golden Rule.
- **P.O. Boxes are not accepted as a Primary Resident Address.**
- **Applications received by Golden Rule more than 15 days after the signed date will not be accepted.**

Mail the Application and Related Forms Packet to the address below.

Be sure to include the following:

- Health insurance quote.
- Initial payment check made payable to "FACT."
- P.A.C. authorization and voided check (if paying monthly).

**Mail to: MedPlan Access
6 Grapevine Place
P.O. Box 2220
West Lafayette IN 47906**