

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 _____

FACT ENFO 0105

If you wish to apply for association group 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 _____
 Child Only (list youngest child as the Primary Applicant) 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 E-mail Address _____

e. Payor: _____
 (If not You): Name _____ E-mail 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

i. Total Annual Household Income: \$15,000 or less \$35,001 to \$50,000 \$75,001 to \$99,999
 \$15,001 to \$35,000 \$50,001 to \$75,000 \$100,000 or more

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	NOT REQUIRED					
<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. Primary Applicant's Mother's Maiden Name: _____ Spouse's Mother's Maiden Name: _____
 (Last Name Only) (Last Name Only)

5. Do all applicants, other than dependent children, read, write, speak, and understand the English language? Yes No
 (A no answer does not eliminate an applicant from eligibility, but merely alerts us that a translator may be necessary for telephone conversations.)

COVERAGE INFORMATION — Must complete for all new applications, including child only.

6. Requested Effective Date: ___/___/___
7. All plans include a preferred network. Network Name: _____
8. 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
9. Requested Health Class: Primary: Preferred Standard I Standard II
 Spouse: Preferred Standard I Standard II
10. For additions and reinstatements, complete only if changing the deductible for all insureds.

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

<input type="checkbox"/> Copay Select SM	FACT Dues	\$	3.00	
<input type="checkbox"/> Copay Saver SM	Base Premium Amount	+	_____	
<input type="checkbox"/> \$ 500 (Copay Select only)	PLAN ENHANCEMENTS — See current brochure and inserts for availability			
<input type="checkbox"/> \$1,000 (Copay Select only)	<input type="checkbox"/> \$5 Million Lifetime Maximum	+	_____	Optional
<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> 24 Month Initial Rate Guarantee	+	_____	Optional
<input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000	<input type="checkbox"/> No Annual Maximum Prescription Drug	+	_____	Optional
	<input type="checkbox"/> \$25 Office Visit Copay	+	_____	Optional
	<input type="checkbox"/> 2 Additional Dr. Office Visits	+	_____	Optional
	<input type="checkbox"/> Prescription Drug Copay	+	_____	Optional
Coinsurance choices with Copay Select	OPTIONAL BENEFITS — See current brochure and inserts for availability			
<input type="checkbox"/> 0% <input type="checkbox"/> 20% <input type="checkbox"/> 30%	<input type="checkbox"/> Enhanced Term Life: Primary <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000	+	_____	Optional
	<input type="checkbox"/> Enhanced Term Life: Spouse <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000	+	_____	Optional
	<input type="checkbox"/> Accidental Death: Primary	+	_____	Optional
	<input type="checkbox"/> Accidental Death: Spouse	+	_____	Optional
	<input type="checkbox"/> Supplemental Accident: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	+	_____	Optional
	<input type="checkbox"/> Term Life	+	_____	Optional
	<input type="checkbox"/> Maternity Benefit	+	_____	Optional
	<input type="checkbox"/> Preventive Care	+	_____	Optional
	<input type="checkbox"/> UnitedHealthcare Dental: <input type="checkbox"/> Premier SM <input type="checkbox"/> Value SM (if available)	+	_____	Optional
	<input type="checkbox"/> UnitedHealthcare Vision (if available)	+	_____	Optional
	<input type="checkbox"/> HSA Deposit	+	_____	\$25 Monthly Min.
	Total Monthly Payment	= \$	_____	
<input type="checkbox"/> HSA 100 [®]	One-Time HSA Set-Up Fee	+	_____	\$10
<input type="checkbox"/> HSA 70 SM	<input type="checkbox"/> One-Time HSA Indemnity Rider	+	_____	Optional
Single	Initial Monthly Payment (Make check payable to "FACT")	= \$	_____	
<input type="checkbox"/> \$1,250	If Quarterly, Total Monthly Payment x 3	= \$	_____	
<input type="checkbox"/> \$2,500	One-Time HSA Set-Up Fee	+	_____	\$10
<input type="checkbox"/> \$3,500	<input type="checkbox"/> One-Time HSA Indemnity Rider	+	_____	Optional
<input type="checkbox"/> \$5,000	Initial Quarterly Payment (Make check payable to "FACT")	= \$	_____	
Family				
<input type="checkbox"/> \$2,500				
<input type="checkbox"/> \$5,000				
<input type="checkbox"/> \$7,000				
<input type="checkbox"/> \$10,000				

11. Initial Payment With Application (Premium will be verified and may be adjusted up or down during the underwriting process): 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)

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

12. 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

13. Will the term life benefit replace any existing **life** insurance? Yes No
 Company Name _____ Policy Number _____
14. 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.) Yes No
 Person: _____ Company: _____ Action Taken: _____
 Date: _____ Reason for Action: _____
15. Has any applicant previously applied for, or been covered by, Golden Rule or UnitedHealthcare? Yes No
 Name _____ Policy/Certificate Number _____

DRIVING — FOR ALL APPLICANTS

16. 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? Yes No
 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." Yes No

MEDICAL HISTORY — FOR ALL APPLICANTS

IMPORTANT! YOU MUST PROVIDE DETAILS OF EACH YES ANSWER IN THE "MEDICAL HISTORY DETAILS" SECTION.

17. 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
18. In the last 5 years, has any applicant filed a claim and/or received benefits from disability insurance or Worker's Compensation? Yes No
19. 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? Yes No
20. In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind? Yes No
21. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more? Yes No
22. 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? Yes No
23. Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks* per week? Yes No
 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).

MEDICAL HISTORY — FOR ALL APPLICANTS (continued)

24. 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. Has any applicant: (a) tested positive for exposure to the HIV infection; (b) been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) caused by HIV infection; or (c) been diagnosed as having any other sickness or condition derived from an HIV infection? | <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 |
| 25. Digestive System | | | 32. 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"/> |
| 26. Urinary System | | | 33. 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"/> |
| 27. 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"/> |
| 28. Mouth, Throat, or Jaw | <input type="checkbox"/> | <input type="checkbox"/> | 34. Muscular or Skeletal System | | |
| 29. Skin Disorders | <input type="checkbox"/> | <input type="checkbox"/> | a. joints, bones, spine, or back? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. 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"/> | 35. 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"/> |
| 31. Male or Female Reproductive System | | | 36. 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"/> | 37. 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 |
| 38. 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"/> | | | |

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

This policy is primarily governed by the laws of Illinois. As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida-approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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.
- (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 _____
Spouse (If to be covered)

X _____
Parent/Guardian (If you are a minor) Relationship

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.

I agree with the answer given for Question 13, "Will the term life benefit replace any existing life insurance?" (If the response shown for Question 13 does not reflect your understanding, please check this box and attach an explanation.)


X _____
Signature of Licensed Broker

X _____
Print Full Name

Broker Number

FL Agent Number

Broker E-mail Address

X 
Countersigned by Licensed Resident Agent

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

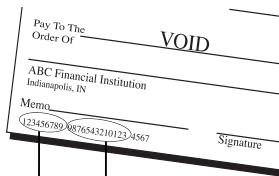
ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION — ONLY IF PAYING BY EFT

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

E-mail 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

Name as Printed on Card: _____

Billing Address _____ City _____ State _____ ZIP _____

Card Number: _____

X _____

Signature of Authorized User

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

FLORIDA CERTIFICATION

Review the statements and sign where appropriate.

Decide whether or not all of the statements 1-6 apply to you.

1. I do not have any other health insurance coverage (or it will be involuntarily terminated soon).
2. I have been insured by *creditable coverage*¹ (as defined below) for the last 18 months or more with no lapse in coverage of more than 63 days.
3. My most recent coverage was under a *group health plan*² (as defined below), a governmental plan, or a church plan; or under an individual plan that terminated due to: the insurer's insolvency; the insurer's discontinuance of all its individual coverage in Florida; or the fact that I no longer live in a Florida service area of my prior insurer's network plan.
4. My most recent coverage was not terminated due to nonpayment of premiums, fraud, or intentional misrepresentations.
5. I am not eligible for any coverage under a conversion plan, a *group health plan*² (as defined below), Medicare, or Medicaid.
6. I accepted and exhausted any group continuation of coverage (including COBRA) that was offered to me.

Carefully review the statements above and sign under A. or B.

A. One or more of the six statements above **do not** apply to me.

Signature _____

Date _____

OR

B. I represent that all six of the statements above **do** apply to me.

Signature _____

Date _____

¹*Creditable coverage* includes group or individual health insurance coverage, Medicare, Medicaid, Armed Forces coverage, Indian or tribal coverage, state risk pool coverage, public health coverage, and Peace Corps Act coverage. A plan is NOT *creditable coverage* if it: a) provides coverage only for accidents, disability, or liability; b) is credit-only insurance; or c) is secondary to other insurance.

²Generally, a *group health plan* is any coverage existing in connection with employment. Included are: employer-sponsored plans (so long as at least one employee participates); coverage of an employee under an individual policy of insurance that is part of a plan, fund, or program established or maintained by an employer that provides medical care to employees or their dependents; coverage of a business owner so long as at least one employee other than the business owner and the business owner's spouse also participates in the plan; and coverage of partners in a plan maintained by the partnership.