

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			Birth Date	Age	Sex	Height	Weight
a. Name (Last, First, M.I.)	Not Required						
b.							
c.							
d.							
e.							

4. Primary Applicant's Address (P.O. Boxes are not accepted.)

 Street (Include Apt.) City State ZIP

5. Phone Numbers: () ()
 Home Other Best number and times 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 \$15,000 or less \$35,001 to \$50,000 \$75,001 to \$99,999
 Prior Employment (If within 2 years): _____ Household Income: \$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)

Primary Applicant's initials _____ Spouse's initials _____ Date ____ / ____ / ____



COVERAGE INFORMATION

11. Requested Health Class: Primary: Preferred Stand. I Stand. II
 Spouse: Preferred Stand. I Stand. II
 Tobacco Use: Primary Yes No Spouse Yes No Child a. Yes No Child b. Yes No Child c. Yes No Child d. Yes No Child e. Yes No

Requested Effective Date: ____/____/____
 Plan includes Preferred Network; if not wanted, check here
 Network: _____
 Special Instructions: _____

(See Question 31 for applicants age 18 and older, including dependent children)

Copay Plans	<input type="checkbox"/> Copay Select SM <input type="checkbox"/> \$ 500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$1,500	HSA Plans	Single 2007/2008 <input type="checkbox"/> HSA <input type="checkbox"/> \$1,100/\$1,100 <input type="checkbox"/> \$2,200/\$2,200 <input type="checkbox"/> HSA 100 [®] <input type="checkbox"/> \$1,850/\$1,900 <input type="checkbox"/> \$3,800/\$3,850 <input type="checkbox"/> HSA <input type="checkbox"/> \$2,850/\$2,900 <input type="checkbox"/> \$5,650/\$5,800 <input type="checkbox"/> HSA Saver [®] <input type="checkbox"/> \$3,500/\$3,500 <input type="checkbox"/> \$7,500/\$7,500 <input type="checkbox"/> \$5,000/\$5,000 <input type="checkbox"/> \$10,000/\$10,000	Plan 80, Plan 100, and Saver 80	<input type="checkbox"/> Saver 80 SM <input type="checkbox"/> \$ 500 (Saver 80 only) <input type="checkbox"/> Plan 80 SM <input type="checkbox"/> \$1,000 (Saver 80 only) <input type="checkbox"/> Plan 100 [®] <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000
	<input type="checkbox"/> Copay Saver SM <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000		<input type="checkbox"/> Term Life Benefit <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> Preventive Care (Copay Saver only) <input type="checkbox"/> 2 Additional Dr. Visits a Year (Copay Saver only) <input type="checkbox"/> Prescription Drug-no annual max. (Copay Select only)		<input type="checkbox"/> Term Life Benefit <input type="checkbox"/> Preventive Care <input type="checkbox"/> Hospital Indemnity Rider (Not Available with \$1,100 or \$2,200 deductible)
Optional		Optional		Optional	

BILLING (or attach health insurance quote)

12. Initial Payment With Application: Check EFT Credit Card
 Ongoing Payments: Monthly (EFT) List Bill (include forms) Quarterly Direct Bill

FACT Dues	\$	3.00	
Base Premium Amount	+		
Term Life Benefit	+		Optional
Supplemental Accident	+		Optional
Preventive Care	+		Optional
2 Additional Dr. Visits a Year	+		Optional
Prescription Drug-no annual max.	+		Optional
Prescription Drug Card	+		Optional
HSA Deposit	+		\$25 Monthly Minimum (only with HSA)
Child(ren) Admin. Fee	+		\$5 per month (only if primary applicant <18 yrs)
Total Monthly Payment	= \$		→ If Quarterly → X3= \$
One-Time HSA Set-Up Fee	+		\$10 only with HSA
One-Time HSA Indemnity Rider	+		
Initial Payment	= \$		Make check payable to "FACT:" = \$

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: _____
 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. Is any applicant applying for this plan as an "Eligible Individual" entitled to guaranteed coverage under Virginia state law implementing the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA)? Yes No
 16. 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: _____

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

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

DRIVING

18. 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. Name of applicant(s)? _____ Yes No
- b. Does the applicant have a valid motorcycle license? Yes No
- c. Within the last 24 months, has the applicant had his/her license suspended or revoked? Yes No
- 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." Yes No

MEDICAL HISTORY -- FOR ALL APPLICANTS

IMPORTANT! PLEASE PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS."

- | | Yes | No | | Yes | No |
|--|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 19. 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: | | |
| 20. Do any applicants, other than dependent children, not read, write, speak, and understand the English language? | <input type="checkbox"/> | <input type="checkbox"/> | a. had a complicated pregnancy or delivery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. Do you have an adoption pending? | <input type="checkbox"/> | <input type="checkbox"/> | b. tested positive for antibodies to the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. 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. been hospital confined, had surgery, or discussed surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the: | | | 26. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the: | | |
| a. gallbladder? | <input type="checkbox"/> | <input type="checkbox"/> | a. heart or circulatory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. pancreas or liver? | <input type="checkbox"/> | <input type="checkbox"/> | b. nervous system? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. joints or spine? | <input type="checkbox"/> | <input type="checkbox"/> | c. digestive system? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. kidney? | <input type="checkbox"/> | <input type="checkbox"/> | d. muscular or skeletal system? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. eyes, ears, or nose? | <input type="checkbox"/> | <input type="checkbox"/> | e. respiratory system? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. mouth, throat, or jaw? | <input type="checkbox"/> | <input type="checkbox"/> | f. male or female reproductive system, including infertility? | <input type="checkbox"/> | <input type="checkbox"/> |
| 24. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of: | | | g. urinary system? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. high blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | h. thyroid, breast, or other glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | 27. 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"/> |
| c. headaches? | <input type="checkbox"/> | <input type="checkbox"/> | 28. 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"/> |
| d. paralysis? | <input type="checkbox"/> | <input type="checkbox"/> | 29. 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"/> |
| e. arthritis? | <input type="checkbox"/> | <input type="checkbox"/> | 30. 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"/> |
| f. convulsions or epilepsy? | <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). | | |
| g. elevated cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | 31. 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"/> |
| h. sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> | 32. 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. | | |
| 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. Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| m. tumor, cyst, polyp, lump, or growth of any kind? | <input type="checkbox"/> | <input type="checkbox"/> | | | |
| n. mental, emotional, or behavioral disorder? | <input type="checkbox"/> | <input type="checkbox"/> | | | |

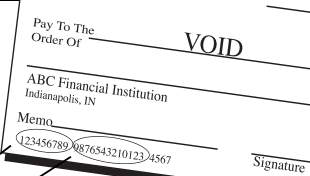
ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION -- ONLY IF PAYING BY EFT

I (we) hereby authorize FACT or Golden Rule to initiate debit entries to the account indicated below. I also authorize the named depository 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.

Nine-digit Check Routing No. _____

Checking 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.

Account Holder's Signature X _____

E-mail Address _____

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 authorize Exante to share information about my HSA with the authorized user named and to allow withdrawals by check, debit card, or other means to be 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 _____

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 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-0806

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"
- EFT authorization (if paying via EFT).

Mail to: Golden Rule Insurance Company
 HEALTH APPLICATION
 PO Box 68994
 Indianapolis, Indiana 46268-0994

PART III APPLICATION (You must sign and date in ONE of the boxes below if you signed under B. in Part I.)

Applying for a Portability Plan (guaranteed-issue coverage)

I signed under B. in Part I because all six statements under Part I apply to me. While I understand that Golden Rule makes the final determination regarding eligibility, I am applying for a portability plan. My signature below confirms that my portability rights were explained and the minimum and maximum rates were made available to me.

X _____
Signature of Proposed Insured

X _____
Date

Not Applying for a Portability Plan (guaranteed-issue coverage)

Even though I believe I am eligible for a portability plan, I am not applying for a portability plan. My signature below confirms that my portability rights were explained; portability coverage was offered; the minimum and maximum rates were made available, and I do not wish to pursue this option at this time.

I realize if I am eligible and I do not apply for a portability plan within 62 days of losing my prior coverage, this right may no longer be available to me.

X _____
Signature of Proposed Insured

X _____
Date

PART IV PROOF OF CREDITABLE COVERAGE (Complete ONLY if you are applying for a portability plan.)

Option 1

OR

Option 2

- 1) Provide the information requested below; and
- 2) Provide copies of "certificates of creditable coverage" as evidence of coverage under each health plan for the past 18 months. *Certificates of creditable coverage* are available from your prior health insurance administrators.

- 1) Provide the information requested below; and
- 2) Provide copies of "supporting documents" as evidence of coverage under each health plan for the past 18 months. *Supporting documents* may include copies of the following: identification card, explanation of benefits, pay stubs showing a deduction for health coverage, insurance certificate, and/or cancelled premium payment checks.

Details About Your Most Recent Coverage

Most Recent Employer Name and Address		Employment Termination Date		Phone No.
Most Recent Insurance Company Name and Address	Effective Date	Termination Date	ID No.	Phone No.
Other Insurance Companies for the Past 18 Months	Effective Date	Termination Date	ID No.	Phone No.