The questions and statements below are required by Colorado Regulation 4-2-37. **Colorado**

For Golden Rule plans, if the answer to question 1 is "yes," we are unable to issue coverage; if the answer is "no," please continue to the application.

1. Will an employer of fifty (50) or fewer eligible employees be paying for or reimbursing an employee through wage adjustment, or a health reimbursement arrangement for any portion of the premium on the policy being applied for? ❑ Yes ❑ No **If you answered "yes," please continue. If you answered "no," you may STOP.**
2. Did the employer have a small group health benefit plan providing coverage to any employee in the twelve (12) months prior to the date of this application? ❑ Yes ❑ No

If the answer to both questions 1 and 2 is "yes," the applicant may not be issued an individual policy with the premiums, or portion thereof, paid or reimbursed by the employer.

If the answer to question 1 is "yes" and the answer to question 2 is "no," the applicant must submit a signed affidavit from the employer certifying that the employer has not had a small group health benefit plan providing coverage to any employee in the previous twelve (12) months. The affidavit form to be executed by the employer is attached. The submission of this affidavit does not guarantee that the individual policy you are applying for will be issued by the carrier.

As explained in our Health Insurance Certification, our plans are not designed as employer-provided insurance and cannot be used by an employer to provide insurance for employees. As a result, no affidavit form is provided as referenced above.

Primary Applicant (You) _____ Date _____

40749-G-0911

MUST BE COMPLETED BY THE APPLICANT(S)

GOLDEN RULE INSURANCE COMPANY
APPLICATION FOR INSURANCE

PLEASE PRINT IN BLACK INK

APPLICANT(S) INFORMATION

1. **REASON FOR APPLICATION:** ❑ New Application ❑ Add a dependent ❑ Reinstatement ❑ Change deductible ID Number _____ (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 Email Address

e. Payor: _____
(If not You): Name Email 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

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

Gender	Name (Last, First, M.I.)	Social Security No.	Birth Date	Age	MUST BE ACCURATE Height	MUST BE ACCURATE Weight
❑ Male ❑ Female	a. Primary (You)					
❑ Male ❑ Female	b. Spouse					
❑ Male ❑ Female	c. Child					
❑ Male ❑ Female	d. Child					
❑ Male ❑ Female	e. Child	NOT REQUIRED				
❑ Male ❑ Female	f. Child					
❑ Male ❑ Female	g. Child					

If you need to list additional dependents, please use lined paper, sign and date it, and check this box. ❑

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4. Do all of the applicants, other than the dependent children, read, write, speak, and understand the English language? . . . . . ❑ Yes ❑ No

COVERAGE INFORMATION — Must complete for all new applications.

5. Requested Effective Date: __ __/__ __ / __ __ __ __

6. All plans include a preferred network. Network Name:_____

7. 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

8. **Requested Health Class:** Primary: ❑ Preferred ❑ Standard I ❑ Standard II
Spouse: ❑ Preferred ❑ Standard I ❑ Standard II

9. **For additions and reinstatements, complete only if changing the deductible for all insureds.**

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

❑ **Copay Select℠**

❑ $1,000 ❑ $1,500 ❑ $2,500 ❑ $3,500
❑ $5,000 ❑ $7,500 ❑ $10,000

Coinsurance —
Out-of-Pocket Maximum After Deductible
❑ 0% ($1,000 and $1,500 Deductible not available)
❑ 80/20 — $3,000
❑ 70/30 — $5,000

❑ **Plan 100®**
❑ **Plan 80℠**
❑ **Saver 80℠**

❑ $1,000 (Saver 80℠ Only)
❑ $1,500 (Saver 80℠ and Plan 80℠ Only)
❑ $2,500 ❑ $5,000
❑ $7,500 ❑ $10,000

❑ **HSA 100®**
❑ **HSA 70℠**

❑ $1,250 (Single HSA 70℠ Only)
❑ $2,500 (Single and Family HSA 70℠ Only)
❑ $3,000 (Single Only)
❑ $3,500 (Single Only)
❑ $5,000 (Single and Family)
❑ $6,000 (Family Only)
❑ $7,000 (Family Only)
❑ $10,000 (Family Only)

Base Premium Amount	**$** _____	
OPTIONAL BENEFITS — See current brochure and inserts for availability		
❑ $25 Office Visit Copay	+ _____	Optional
❑ Supplemental Accident: ❑ $500 ❑ $1,000 ❑ $2,500 ❑ $5,000 ❑ $10,000	+ _____	Optional
❑ Term Life: Primary ❑ $50,000 ❑ $100,000 ❑ $150,000	+ _____	Optional
❑ Term Life: Spouse ❑ $50,000 ❑ $100,000 ❑ $150,000	+ _____	Optional
❑ Accidental Death: Primary	+ _____	Optional
❑ Accidental Death: Spouse	+ _____	Optional
❑ UnitedHealthcare Vision (if available)	+ _____	Optional
❑ HSA Deposit	+ _____	$25 Monthly Min.
Total Monthly Payment	**= $**_____	
One-Time HSA Set-Up Fee	+ _____	$10
Initial Monthly Payment (Payable to "Golden Rule")	**= $** _____	
If Quarterly, Total Monthly Payment x 3	**= $**_____	
One-Time HSA Set-Up Fee	+ _____	$10
Initial Quarterly Payment (Payable to "Golden Rule")	**= $** _____	

10. **Initial Payment With Application**: ❑ Check ❑ EFT ❑ Credit Card
Ongoing Payments: Monthly ❑ EFT (no billing fee) ❑ Direct Bill ($10 monthly billing fee)
Quarterly ❑ Direct Bill ($10 quarterly billing fee)

IMPORTANT: Premium will be verified and may be adjusted up or down during the underwriting process. Electronic Funds Transfer (EFT) and Credit Card payments will only be collected upon approval of your application. Checks are deposited upon receipt.

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

Yes No

11. Within the last 90 days, has any applicant **been covered by** any type of **medical** insurance? ..... ❑ ❑

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

You normally do not require more than one policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplement policy. If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

To the best of your knowledge: **Yes** **No**

12. Do you have another accident and sickness insurance policy or contract in force? ..... ❑ ❑
    (a) If so, with which company? _____
    (b) If so, do you intend to replace your current accident and sickness insurance with this policy? ..... ❑ ❑
13. Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy? ..... ❑ ❑
    (a) If so, with which company? _____
    (b) What kind of policy? _____
14. Are you covered for medical assistance through the state Medicaid program? ..... ❑ ❑
    (a) As a Specified Low Income Medicare Beneficiary (SLMB)? ..... ❑ ❑
    (b) As a Qualified Medicare Beneficiary (QMB)? ..... ❑ ❑
    (c) For other Medicaid medical benefits? ..... ❑ ❑
15. Do you have another insurance policy or contract in force that you do not intend to replace? ..... ❑ ❑
    (a) If so, with which company? _____
    (b) If so, will the coverage terminate prior to the Requested Effective Date shown in the Coverage Information Section of this application? ❑ ❑
    (c) If so, on what date will the coverage terminate? _____/_____/_____
16. Will the term life benefit replace any existing **life** insurance? ..... ❑ ❑

    Company Name _____ Policy Number _____
17. 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.) ..... ❑ ❑

    Person: Company: Action Taken:

    Date: Reason for Action:
18. Has any applicant previously applied for, or been covered by, Golden Rule or UnitedHealthcare? ..... ❑ ❑

    Name _____ Policy/Certificate Number _____

DRIVING — FOR ALL APPLICANTS

Yes No

19. In the last 24 months, has any applicant participated in driving any type of motorcycle? ..... ❑ ❑

    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? ..... ❑ ❑

    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." ..... ❑ ❑

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MEDICAL HISTORY — FOR ALL APPLICANTS

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

		Yes	No
20.	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?	❑	❑
21.	In the last 5 years, has any applicant filed a claim and/or received benefits from disability insurance or Worker's Compensation?	❑	❑
22.	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?	❑	❑
23.	In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind?	❑	❑
24.	In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more?	❑	❑
25.	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?	❑	❑
26.	Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks* per week? 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).	❑	❑

		Yes	No
27.	In the last 10 years, has any applicant:		
a.	Had a complicated pregnancy or delivery (including a caesarean section)?	❑	❑
b.	Consulted a health care provider for any condition or symptom(s) for which a diagnosis has not been established?	❑	❑
c.	Had any signs, symptoms, diagnosis, or treatment of Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness, or tested positive for antibodies to the HIV virus?	❑	❑
d.	Had any abnormal physical exam, X-ray, EKG, MRI, CT scan, or any adverse or abnormal laboratory or other test results?	❑	❑
e.	Been confined in a hospital for anything other than childbirth?	❑	❑
f.	Had surgery?	❑	❑
g.	Had placement, treatment, or maintenance of an internal or external implant or prosthetic device?	❑	❑

MEDICAL HISTORY — FOR ALL APPLICANTS (continued)

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
28.	**Digestive System**		
a.	gallbladder, pancreas, or liver?	❑	❑
b.	ulcers?	❑	❑
c.	gastroesophageal reflux disease (acid reflux, GERD)?	❑	❑
d.	rectal bleeding?	❑	❑
e.	other digestive system disorder or condition?	❑	❑
29.	**Urinary System**		
a.	kidney?	❑	❑
b.	other urinary system disorder or condition?	❑	❑
30.	**Eyes, Ears, Nose**		
a.	ear or sinus infections (more than two in the past 12 months)?	❑	❑
b.	other disorder or condition of the eyes, ears, or nose?	❑	❑
31.	**Mouth, Throat, or Jaw**	❑	❑
32.	**Skin Disorders**	❑	❑
33.	**Heart or Circulatory System**		
a.	chest pain?	❑	❑
b.	high or low blood pressure?	❑	❑
c.	elevated cholesterol?	❑	❑
d.	stroke?	❑	❑
e.	shunts, stents, or pacemaker?	❑	❑
f.	other heart or circulatory system disorder or condition?	❑	❑
34.	**Male or Female Reproductive System**		
a.	infertility or erectile dysfunction?	❑	❑
b.	sexually transmitted disease?	❑	❑
c.	abnormal mammogram or Pap smear?	❑	❑
d.	other male or female reproductive system disorder or condition?	❑	❑
35.	**Blood, Gland, Endocrine, or Metabolic**		
a.	thyroid, breast, or other glands?	❑	❑
b.	diabetes or sugar in the blood or urine?	❑	❑
c.	anemia?	❑	❑
d.	immune system disorder (other than AIDS or HIV)?	❑	❑
e.	other blood, endocrine, or metabolic disorder or condition?	❑	❑
36.	**Brain and Nervous System**		
a.	migraines or chronic or severe headaches?	❑	❑
b.	seizures or epilepsy?	❑	❑
c.	mental, emotional, or behavioral disorder (including anorexia or bulimia)?	❑	❑
d.	multiple sclerosis or paralysis?	❑	❑
e.	other brain or nervous system disorder or condition?	❑	❑
37.	**Muscular or Skeletal System**		
a.	joints, bones, spine, or back?	❑	❑
b.	arthritis or fibromyalgia?	❑	❑
c.	amputation?	❑	❑
d.	other muscular/skeletal system disorder or condition?	❑	❑
38.	**Respiratory System**		
a.	asthma or allergies?	❑	❑
b.	sleep apnea?	❑	❑
c.	other respiratory system disorder or condition?	❑	❑
39.	**Cancer, Cyst, or Tumor**		
a.	cancer?	❑	❑
b.	tumor, cyst, polyp, lump, or growth of any kind?	❑	❑
40.	**Birth Defects or Congenital Abnormalities**		
a.	Down's syndrome?	❑	❑
b.	cerebral palsy?	❑	❑
c.	other birth defect or congenital abnormality?	❑	❑

		Yes	No
41.	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?	❑	❑

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

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

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) There will be no benefits for any loss incurred in the first year of coverage due to a preexisting condition (does not apply to applicants under the age of 19).

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

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

(6) 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.

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

(8) **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.**

(9) 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.

(10) 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.

(11) 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.

(12) 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.

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

(14) If the policy was originally issued to a business group of one, I have completed and signed the Colorado Determination of Self-Employed Business Group of one form included in this application packet.

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

X ____/____/____
Date

BROKER CERTIFICATION

1. List any other health insurance policies/certificates personally sold to the applicant which are still in force. Indicate if policy/certificate is to be replaced.

Name of Company	Type of Coverage	To Be Replaced

2. List any policy/certificate personally sold to the applicant within the past five (5) years which is no longer in force.

Name of Company	Type of Coverage	Policy/Certificate Number

_____ _____
Licensed Agent or Broker (Please Print.) Individual Producer #

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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 16, "Will the term life benefit replace any existing **life** insurance?" (If the response shown for Question 16 does not reflect your understanding, please check this box and attach an explanation. ❑)

X _____ X _____

Signature of Licensed Broker | Print Full Name

Broker Number

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 unless I am a self-employed business group of one, as determined based on the completion of the Colorado Determination of Self-Employed form:

(a) my employer is not contributing any part of the premium, directly or through wage adjustments or other means of reimbursement;
(b) neither I nor my dependents intend to treat this insurance as part of a plan or program under section 106, 125, or 162 of the U.S. Internal Revenue code; and
(c) this plan was not marketed to me through my employer's place of business.

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.

063B-0711

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: Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.

Signed X ___/___/_____ X _____

Date | Signature of Primary Applicant (You)

X _____ X _____

Signature of Parent/Guardian (If you are a minor) | 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, pharmacy benefit manager, 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 ___/___/_____ X _____

Date | Signature of Primary Applicant (You)

X _____ X _____

Signature of Parent/Guardian (If you are a minor) | Signature of Spouse (If to be covered)

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

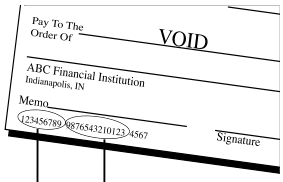
Authorized User's
Social Security No.

155X-1108

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

I (we) hereby authorize 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

Email Address _____

INITIAL PAYMENT CREDIT CARD AUTHORIZATION

I authorize 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

Billing ZIP Code:

Card Number:

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.
- **Coverage is not available if:**
  - Any family member, whether or not named in this application, is currently pregnant; or
  - The applicant has not resided in the U.S. for at least 12 consecutive months.

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.

COLORADO DETERMINATION OF SELF-EMPLOYED — Business Group of One Form

A person who answers "yes" to all four questions below meets the legal definition of a "self-employed business group of one" in Colorado.

SECTION 1

❑ Yes ❑ No 1. Are you or your spouse (if applying for coverage) either a self-employed person with no employees or a sole proprietor who is not offering or sponsoring health care coverage to employees?

❑ Yes ❑ No 2. Have you or your spouse (if applying for coverage) carried on significant business activity as a self-employed person or sole proprietor for a period of at least one year prior to application for coverage?

❑ Yes ❑ No 3. Do you or your spouse (if applying for coverage) have gross income from self-employment or sole proprietorship as indicated on Federal Internal Revenue forms 1040, Schedule C, F, or SE, or other forms recognized by the Federal Internal Revenue Service for income reporting purposes which you or your spouse have derived a substantial part of your or your spouse's income from your or your spouse's business as a self-employed person or sole proprietor for one year out of the past three years? Note: "Substantial part of your or your spouse's income" means income derived from business activities of the business group of one that is sufficient to pay for the annual premiums for the business group of one's health benefit plan.

❑ Yes ❑ No 4. Do you or your spouse (if applying for coverage) work a minimum of 24 hours a week on a permanent basis?

If you or your spouse (if applying for coverage) answered "Yes" to all of the above questions, complete Section 2, read Sections 3 and 4, and sign and date the form.

If both you and your spouse (if applying for coverage) answered "No" to any of the above questions, skip Sections 2 and 3, read Section 4, and sign and date the form.

SECTION 2 DO NOT complete this section if you are applying for coverage for yourself with no additional family members.

When a Business Group of One applies for an individual health benefit plan to include coverage for his/her family, Colorado law requires that the insurance carrier accept or reject the entire family, unless the applicant waives coverage for a family member who has other coverage in effect. If you are applying for coverage for your family, please list all your dependents (**even if not applying for coverage)** and provide the information requested below:

	Full Name (Please Print)	**Birth Date**	**Waiving Coverage**	**Type of Other Health Coverage**	**Effective Date of Other Coverage**
Spouse			❑ Yes ❑ No		
Dependent 1			❑ Yes ❑ No		
Dependent 2			❑ Yes ❑ No		
Dependent 3			❑ Yes ❑ No		

If you need to list additional dependents, please use lined paper, sign and date it, and check this box. ❑

SECTION 3

Please read and sign the following disclosure required by Colorado law:

I/we meet the definition of a Self-Employed Business Group of One as indicated in Section 1 of this form. I/we understand that by purchasing an individual policy instead of small group coverage, I/we give up what would otherwise be my/our right to purchase, during open enrollment periods as specified by law, a Business Group of One Standard, Basic, or other small group health benefit plan from a small employer carrier for a period of three (3) years after the effective date of the individual health benefit plan for which I am/we are applying. I/we understand that this will be the case unless a small employer carrier voluntarily permits me/us to purchase small group coverage within such three-year period.

I/we understand that the factors used to set new and renewal rates for the individual policy I/we want to purchase consist of: the policy plan, age and sex of covered persons, type and level of benefits and selected options, effective date of the plan, time the policy has been in force, ZIP Code of residence on the premium due date, Medicare eligibility status, tobacco use, underwriting classification at issue, and mandated state requirements. By comparison, the rating factors that would apply if I/we purchased a small group business group of one policy are limited to: plan design; the carrier's overall cost and utilization trends (index rate); my/our age(s); my/our family size; a factor that reflects the cost of care where I/we live; health status; claims experience; standard industrial classification; and/or tobacco use.

I/we have been given a health plan description form showing the benefits under Colorado's small group Standard Health Benefits Plans. I/we have also been given a Colorado Health Plan Description for the plan for which I am/we are applying.

SECTION 4

I/we attest that the answers to the questions contained in this form are true and correct. I/we further certify that the statements and representations contained in Sections 2 and 3 of this form, if applicable, are true and correct. I/we understand that this form will become part of my/our application for insurance provided by Golden Rule Insurance Company.

X _____ X _____ _____

Signature of Applicant — Signature of Spouse — Date

_____

Applicant's and/or Spouse's Business

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

GOLDEN RULE INSURANCE COMPANY: 7440 WOODLAND DRIVE • INDIANAPOLIS, INDIANA 46278-1719

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Golden Rule Insurance Company. Your new policy will provide ten (10) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this accident and sickness coverage is a wise decision, you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR BROKER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (check one):

____ Additional benefits.
____ No change in benefits, but lower premiums.
____ Fewer benefits and lower premiums.
____ Other (please specify). _____

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim may have been payable under your present policy.

2. State law provides that your replacement policy or contract may not contain new preexisting conditions, waiting periods, elimination periods or probationary periods. The issuer will waive any time periods applicable to preexisting conditions, waiting periods, elimination periods, or probationary periods in the new policy (or coverage) for similar benefits to the extent such time was spent (depleted) under the original policy.

3. If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

_____
Signature of Broker

_____
Typed Name of Broker

_____
Address of Broker

_____ _____
Applicant's Signature Date

Golden Rule's Copy

Oct 1 2012 02:53:07 pm

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_____

Signature of Broker

_____

Typed Name of Broker

_____

Address of Broker

_____ _____

Applicant's Signature Date

Applicant's Copy

Oct 1 2012 02:53:07 pm