



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.

"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."

To the best of your knowledge:

	Yes	No
7. Do you have another insurance policy or contract in force? .....	<input type="checkbox"/>	<input type="checkbox"/>
(a) If so, with which company? _____		
(b) If so, do you intend to replace your current accident and sickness insurance with this policy? .....	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy? .....	<input type="checkbox"/>	<input type="checkbox"/>
(a) If so, with which company? _____		
(b) What kind of policy? _____		
9. Are you covered for medical assistance through the state Medicaid program? .....	<input type="checkbox"/>	<input type="checkbox"/>
(a) As a Specified Low Income Medicare Beneficiary (SLMB)? .....	<input type="checkbox"/>	<input type="checkbox"/>
(b) As a Qualified Medicare Beneficiary (QMB)? .....	<input type="checkbox"/>	<input type="checkbox"/>
(c) For other Medicaid medical benefits? .....	<input type="checkbox"/>	<input type="checkbox"/>

### STATEMENT OF UNDERSTANDING

I have read this application and represent that the information shown on it is true and complete. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule at its Lawrenceville or Indianapolis Office with this application; (b) no benefits will be paid for a health condition that exists prior to the date insurance takes effect; and (c) if coverage is issued, the coverage will not be a continuation of any prior coverage. Incorrect or incomplete information on this application may result in avoidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy that may be issued. I understand that for an application sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after receipt by Golden Rule. I understand that for a mailed application, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after the **postmark date** affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (i) the requested effective date; or (ii) the date received by Golden Rule at its Lawrenceville or Indianapolis Office. I understand that the broker is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

X _____	X _____	X _____
Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child	State where you signed this application	Date you signed and read application

### BROKER CERTIFICATION

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

**Payment Options: *Must choose one***

**Single Payment: Check or money order \$ Amt.** \_\_\_\_\_ (Total Single Payment on reverse. Includes \$20 nonrefundable application fee.)  
For this method of payment, you must make check or money order payable to Golden Rule. (EFT also available with online application)

**OR**

**Single Payment: Credit card \$ Amt.** \_\_\_\_\_ (Total Single Payment on reverse. Includes \$20 nonrefundable application fee.)  
For this method of payment, you must complete the Credit Card Authorization below.

**Credit Card Authorization**  Visa  MasterCard

I authorize Golden Rule Insurance Company to bill my Visa/MasterCard account for the total payment.

Account No. \_\_\_\_\_

Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_

\_\_\_\_\_  
Name on Credit Card X \_\_\_\_\_ Signature of Authorized User Phone No. \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

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

**OR**

**Monthly Payment: Electronic Funds Transfer (EFT) \$ Amt.** \_\_\_\_\_ (Total Initial Payment on reverse. First month amount (shown) includes a one-time \$20 nonrefundable application fee.) Additional monthly EFT payments will be \$20 less. For this method of payment, you must complete the EFT Authorization below.

**Electronic Funds Transfer (EFT) Authorization**

I (we) hereby authorize 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**

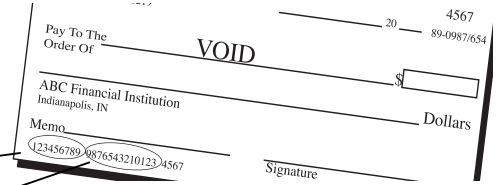
Name \_\_\_\_\_ Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Draft On \_\_\_\_\_ Day X \_\_\_\_\_  
Account Holder's Signature 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 E-mail Address \_\_\_\_\_



**NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**  
GOLDEN RULE INSURANCE COMPANY: 712 Eleventh Street • Lawrenceville, IL 62439  
**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. 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**

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\_\_\_\_\_  
Signature of Broker

\_\_\_\_\_  
Typed Name of Broker

\_\_\_\_\_  
Address of Broker

\_\_\_\_\_  
Applicant's Signature

\_\_\_\_\_  
Date

**Applicant's Copy**

Mar 25 2008 11:25:49 am

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