

Please read the Short Term Medical<sup>SM</sup> brochure and this separate, state-specific Application and Payment Information thoroughly and carefully.

## Instructions for Applying for Coverage

To Calculate Payment(s), follow the numbered steps below and to the right.

- 1) Monthly Base Premium Rates chart.** The rates are separated by Deductible: Male, Female, and Per Dependent Child. Determine which Deductible you are applying for, and find the appropriate rate for your age (as of the requested effective date) and gender. Similarly, find the rates for your spouse and children. If parents are not applying, see **"\*Child(ren) rates without Parents"** under your state's Base Rates chart. Enter the amounts in the spaces shown.  
**Subtotal your Rates.**

- 2) Multiple Person Discount.** If you are the only person applying for coverage, multiply the Subtotal by 1.00. If more than one person is applying for coverage, multiply the Subtotal by 0.90. *(This option will reduce your premium payment.)*  
**Subtotal.**

- 3) Trend Factor.** Using your effective date, determine the trend factor from this chart. Multiply the Subtotal by this number.  
**Subtotal.**

Through September 2007 . . . . .	<b>1.08</b>
October 2007 through March 2008 . . . . .	<b>1.12</b>
April through September 2008 . . . . .	<b>1.16</b>
October 2008 through March 2009 . . . . .	<b>1.20</b>

- 4) ZIP Code Area Factor.** Using your ZIP Code, determine your Area Factor from the state-specific ZIP Code Area Factors chart. Multiply the Subtotal by this number.  
**Subtotal.** This is your Total Health Premium.

Step 5 applies to **Monthly** EFT Payment option only.

- 5)** If Monthly EFT, multiply by the Monthly Processing Fee Factor of 1.10.  
*(Applicable to **Monthly EFT Payment option only.**)*  
**Subtotal.**

Step 6 applies to **Single** Payment option only. *(One single payment.)*

- 6)** If Single Payment option, **determine the Number of Months of coverage.** Multiply by the Number of Months the insurance is needed. *(Applicable to **Single Payment option only.**)*  
**Subtotal.**

- 7) Nonrefundable Application Fee.**  
**Total.**

\*Additional EFT Payments will not include the \$20 Application Fee.  
This fee is only required with the initial payment.

**This is your Total Payment Payable to Golden Rule.**

**If Monthly EFT Payment option:** Complete the **Monthly Payment: Electronic Funds Transfer (EFT) Authorization** section on other side.

**If Single Payment option:** Make check or money order payable to Golden Rule, or complete the **Single Payment: Credit Card** section on the application if you are paying by credit card.

# Colorado

## Application and Payment Information

### Calculate Payment(s)

<b>1) Monthly Base Premium Rate</b> <i>(see chart on right)</i> <b>a) Your Rate</b> ..... <b>b) Spouse Rate</b> ..... <b>c) Child Rate</b> <i>(no. of children ____ x \$ ____)</i> .....	      
<b>Subtotal</b> .....	=
<b>2) Multiple Person Discount</b> ..... <i>(1 person = 1.00) (2 or more = .90)</i>	X
<b>Subtotal</b> .....	=
<b>3) Trend Factor</b> <i>(see chart on left)</i> .....	X
<b>Subtotal</b> .....	=
<b>4) ZIP Code Area Factor</b> <i>(see chart on right)</i> .....	X
<b>Subtotal</b> .....	=

**Two Payment Options:** *You can choose*

**Monthly Payments or One Single Payment**

**Monthly Payments**

**One Single Payment**

	Monthly Payments	One Single Payment
<b>5) Monthly Factor</b> <i>(if paying monthly)</i> .....	X <b>1.10</b>	N/A
<b>Subtotal</b> .....	=	N/A
<b>6) Number of Months</b> <i>(if applicable) (1 to 6)</i> .....	N/A	X
<b>Subtotal</b> .....	=	=
<b>7) Application Fee</b> <i>(one-time fee)</i> .....	+ <b>\$ 20.00*</b>	+ <b>\$ 20.00</b>
<b>Total Payment Payable to Golden Rule</b> .....	= <b>\$</b> _____	= <b>\$</b> _____
	<b>Total Initial Payment</b>	<b>Total Single Payment</b>

## 1) Colorado Monthly Base Premium Rates

AGE	\$250 DEDUCTIBLE		\$500 DEDUCTIBLE		\$1,000 DEDUCTIBLE		\$1,500 DEDUCTIBLE		\$2,500 DEDUCTIBLE	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
To 24	99	94	68	65	47	43	42	38	36	32
25-29	101	106	69	74	49	51	44	45	37	38
30-34	107	122	75	85	53	59	47	53	40	45
35-39	113	139	81	97	57	66	50	59	43	50
40-44	139	160	99	112	73	78	65	69	55	59
45-49	168	183	120	129	90	94	80	84	68	71
50-54	205	207	148	150	114	114	101	101	86	86
55-59	273	245	199	178	155	138	137	122	117	104
60-64	337	280	245	202	190	157	169	139	143	118
Per Dependent Child*	51	51	35	35	22	22	20	20	17	17

**\*Child(ren) rates without Parents.** If you are calculating rates for one child without parents, use the Male or Female "To 24" rate for the child. For two or more children without parents, use the Male or Female "To 24" rate for the youngest child and add the "Per Dependent Child" rate for each additional child.

## 4) Colorado ZIP Code Area Factors

ZIP CODE	AREA FACTOR
80001-80422	1.175
80423, 80424	1.525
80425	1.175
80426	1.525
80427	1.175
80428, 80429	1.525
80430-80434	1.175
80435	1.525
80436-80442	1.175
80443	1.525
80444-80459	1.175
80461, 80463	1.525
80465, 80466	1.175
80467	1.525
80468	1.175
80469	1.525
80470-80476	1.175
80477	1.525
80478	1.175
80479	1.525
80480-80482	1.175
80483-80498	1.525
80501-81121	1.175
81122	1.525
81123-81136	1.175
81137	1.525
81140-81215	1.175
81220	1.525
81221-81248	1.175
81251	1.525
81252, 81253, 81290	1.175
81301-81433	1.525
81434	1.175
81435-81658	1.525

**APPLICATION FOR SHORT TERM MEDICAL<sup>SM</sup> INSURANCE  
GOLDEN RULE INSURANCE COMPANY – LAWRENCEVILLE, ILLINOIS 62439**

Please Print  
in Blue Ink.

No application will be accepted if received by Golden Rule at its Lawrenceville or Indianapolis Office more than 15 days after the date signed.

Yes No

Have you or any other person to be insured been covered under two or more nonrenewable short-term policies during the past twelve months? ..    
If "Yes," then this policy cannot be issued. You must wait six months from the date of your last such policy to apply for a short-term policy.

This policy does not provide portability of prior coverage. As a result, any injury, sickness, or pregnancy for which you have incurred charges, received medical treatment, consulted a health care professional, or taken prescription drugs within twelve months of the effective date of this policy will not be covered under this policy.

PROPOSED  
INSURED

\_\_\_\_\_ / \_\_\_\_ / \_\_\_\_ \*      \_\_\_\_\_       Male  
 First                                  Middle Initial                                  Last                                  Birth Date                                  Age                                  Sex  
 Female

RESIDENT ADDRESS (P.O. Boxes are not accepted.)

\_\_\_\_\_ ( ) \_\_\_\_\_  
 Street (Include Apt.)                                  City                                  State                                  ZIP                                  Telephone No.

1. List below any dependents to be covered under the policy.

Dependent's First Name	Relationship to You	Date of Birth*	Dependent's First Name	Relationship to You	Date of Birth*
_____	<b>Spouse</b>	/ /	_____	_____	/ /
_____	_____	/ /	_____	_____	/ /
_____	_____	/ /	_____	_____	/ /

\*If born within 30 days prior to the effective date of coverage, the person will not be covered under the policy.

2. Are you or is any family member (whether or not named in this application) an expectant mother or father? Yes No  
**If yes, coverage cannot be issued**.....
3. Have you or has anyone named above been declined for insurance due to health reasons? .....    
 If yes, state the name of each person: \_\_\_\_\_  
 (The person(s) named will not be covered under the policy.)
4. Have you or has any person named in Question 1 lived in the 50 states of the USA or the District of Columbia for **less than** ....    
 the past 12 months? If yes, state the name of each person: \_\_\_\_\_  
 (The person(s) named will not be covered under the policy.)
5. Do you or does any person named in Question 1 now have hospital or medical expense insurance that **will not** terminate.....    
 prior to the requested effective date? If yes, state the name of each person: \_\_\_\_\_  
 (The person(s) named will not be covered under the policy.)
6. Within the last 5 years, have you or has anyone listed on the application received medical or surgical consultation, advice, or treatment, including medication, for **any of the following**: liver disorders, kidney disorders, emphysema, diabetes, cancer, heart or circulatory system disorders (including high blood pressure), alcohol or drug abuse or immune system disorders, including HIV infection, or tested positive for HIV infection?.....    
 If yes, state the name of each person: \_\_\_\_\_  
 (The person(s) named will not be covered under the policy.)

**DEDUCTIBLE:**  \$ 250     \$ 500     \$1,000     \$1,500     \$2,500    **REQUESTED EFFECTIVE DATE:** \_\_\_\_/\_\_\_\_/\_\_\_\_  
 (See Statement of Understanding section on the next page.)

**MONTHS OF COVERAGE:**  1 MO.     2 MO.     3 MO.     4 MO.     5 MO.     6 MO.

**Important Note:**  
 "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service.



ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

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 \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_

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

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.

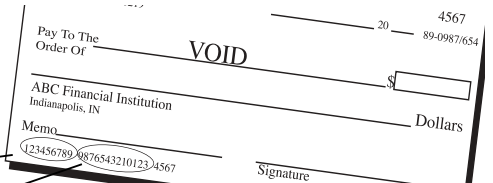
Nine-digit Check Routing No. \_\_\_\_\_ Checking Account No. \_\_\_\_\_

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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- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
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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

**Applicant's Copy**

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