

Please Print
in Black Ink

APPLICATION FOR SHORT TERM MEDICAL INSURANCE
GOLDEN RULE INSURANCE COMPANY -- LAWRENCEVILLE, ILLINOIS 62439

PROPOSED
INSURED

First

Middle Initial

Last

Birth Date

Age

Male
 Female
Sex

RESIDENT
ADDRESS

Street

City

State

ZIP

Telephone No.

1. Are any of your dependents to be covered under the policy/certificate? Yes No If Yes, give details below.

Dependent's Name (Last, First, M.I.)

Relationship to You

Date of Birth*

Spouse

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

2. Are you or is any family member (whether or not named in this application) an expectant mother or father? **If yes, coverage cannot be issued.** Yes No

3. Have you or anyone named above been declined for insurance due to health reasons? Yes No
If yes, state the name of each person: _____
(The person(s) named will not be covered under the policy/certificate.)

4. Have you or 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? Yes No
If yes, state the name of each person: _____
(The person(s) named will not be covered under the policy/certificate.)

5. Do you or any person named in Question 1 now have hospital or medical expense insurance that **will not terminate** prior to the requested effective date? Yes No
If yes, state the name of each person: _____
(The person(s) named will not be covered under the policy/certificate.)

6. Within the last 5 years, have you or 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? Yes No
If yes, state the name of each person: _____
(The person(s) named will not be covered under the policy/certificate.)

DEDUCTIBLE: \$ 250 \$ 500 \$1,000 \$1,500 \$2,500 REQUESTED EFFECTIVE DATE: ____/____/____
(See Statement of Understanding section below.)

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

Subject to a one-time application fee of \$20.

A \$20 fee will be charged for each non-sufficient fund payment transaction. Failure to pay required fees may result in revocation and/or termination of coverage.

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 voidance of coverage, subject to the Time Limits on Certain Defenses provision, and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy/certificate which 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
Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child

X
State where you signed this application

X
Date you signed and read application

David A. Lowe Sr
Licensed Agent or Broker (Please Print)

251926196
Individual Producer #

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



No application will be accepted if received by Golden Rule more than 15 days after the date signed.

PAYOR INFORMATION (If other than Proposed Insured)

Payor: _____
Name _____ E-mail Address _____
Street _____ City _____ State _____ ZIP _____

PAYMENT OPTIONS: SINGLE OR MONTHLY

- Single Payment** (one single payment for all months chosen/lump sum):
 - Check or money order \$ Amount** _____ (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 available with online application)
 - Credit card \$ Amount** _____ (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.

_____ / ____ / ____ X _____
Account No. Expiration Date Signature of Authorized User

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

OR

- Monthly Payment: Electronic Funds Transfer (EFT)** (No Billing Fee): **\$ Amount** _____ (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 — ONLY IF PAYING BY EFT

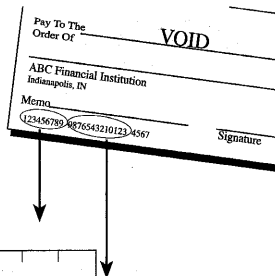
I (we) hereby authorize Golden Rule to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account.

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

X _____

Authorized Account Signature

E-mail Address _____

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.