

Please Print  
in Blue Ink.

APPLICATION FOR SHORT TERM MEDICAL<sup>SM</sup> INSURANCE  
GOLDEN RULE INSURANCE COMPANY – INDIANAPOLIS, INDIANA 46278-1719

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.  Yes  No

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

First Middle Initial Last Birth Date \* Age Sex  
 Male  
 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.

Table with columns: Dependent's Name (Last, First, M.I.), Relationship, Birth Date\*, Gender. Includes a 'Spouse' entry.

\*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, in the process of adopting a child, or undergoing infertility treatment?  Yes  No  
If yes, coverage cannot be issued.

3. Have you or has 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.)

4. 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.)

5. 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, chronic obstructive pulmonary disorder (COPD) or emphysema, diabetes, cancer, heart or circulatory system disorders (including high blood pressure), Crohn's disease or ulcerative colitis, alcohol or drug abuse or immune system disorders, including HIV infection, or tested positive for HIV infection, or does anyone listed on the application currently weigh over 300 pounds?  Yes  No  
If yes, state the name of each person: \_\_\_\_\_  
(The person(s) named will not be covered under the policy.)

PLAN:  Short Term Medical<sup>SM</sup> Plus  Short Term Medical<sup>SM</sup> Value  
DEDUCTIBLE:  \$ 500  \$ 1,000  \$ 1,500  \$ 2,500  \$ 5,000  
 \$ 10,000 (not available with Short Term Medical<sup>SM</sup> Value)  
MONTHS OF COVERAGE:  1  2  3  4

REQUESTED EFFECTIVE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_  
(See Statement of Understanding Section)

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

ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

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





**PAYOR INFORMATION (If other than Proposed Insured)**

Payor:  Name  Email 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.

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

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

OR

**Monthly Payment:**

**Initial Payment**  Check or money order payable to Golden Rule.  EFT (online application only)  
**\$ Amount**  (Total Initial Payment on reverse. First month amount (shown) includes a one-time \$20 nonrefundable application fee.)

**Ongoing Payments (Choose one)**

**Direct Bill** (\$10 monthly billing fee)  
Additional monthly Direct Bill payments will not include the \$20 application fee, however they will include a \$10 monthly billing fee.

**Electronic Funds Transfer (EFT)** (no billing fee)  
Additional monthly EFT payments will not include the \$20 application fee. For this method of payment, you must complete the EFT Authorization below.

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

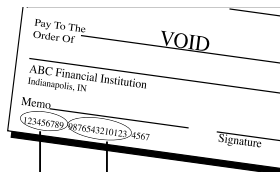
I (we) hereby authorize Golden Rule to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account.

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

Email 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.

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE**

**GOLDEN RULE INSURANCE COMPANY:** 712 Eleventh Street • Lawrenceville, IL 62439

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

**Steven J. Roper**

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

**116 Inverness Dr E, #265, Englewood, CO 80112**

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

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

\_\_\_\_\_  
Date

**Golden Rule's Copy**

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**GOLDEN RULE INSURANCE COMPANY:** 712 Eleventh Street • Lawrenceville, IL 62439

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

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Applicant's Signature

\_\_\_\_\_  
Date

**Applicant's Copy**

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