

AVAILABLE PRODUCTS

REQUESTED EFFECTIVE DATE: _____ / _____ / _____ (See Statement of Understanding section.)

Plan Choices: Dental 50+ Deluxe Dental 50+ Select

OPTIONAL: Vision

Payment Mode: Monthly Quarterly Semiannual Annual

Payment Options: **Initial Payment with Application:**
 Check EFT Credit Card

Ongoing Payments: Monthly EFT Monthly Credit Card
 Direct Bill (quarterly, semiannual and annual only)
 List Bill (include forms; \$25 monthly admin. fee per list bill group)

Initial Premium for Mode Chosen* \$ _____

*The amount charged to your credit card will be the total amount for the payment mode chosen (Monthly, Quarterly, Semiannual, or Annual).

Electronic Funds Transfer (EFT) and Credit Card payments will be collected at the time of application.

If you choose Check as your Initial Payment Method, please mail your check with your completed application - checks are deposited upon receipt.

If Initial Payment is EFT, Ongoing Payment must be EFT.

STATEMENT OF UNDERSTANDING

I personally completed this application. I represent that the answers and statements on it are true, complete, and correctly recorded to the best of my knowledge and belief. I understand and agree that:

- (1) No insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule Insurance Company (GRIC) with this application.
- (2) This application and the initial payment do not give me immediate coverage.
- (3) The proposed insured must be age 50 or older to be eligible for coverage.
- (4) For an application sent by electronic means, insurance, if approved, will be effective the later of:
 - (i) the requested effective date; or
 - (ii) the day after receipt by GRIC.
- (5) 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 GRIC.
- (6) If other dental/vision insurance exists that duplicates coverage under the dental/vision plan being applied for, the existing dental/vision coverage must be terminated prior to the effective date of this coverage.
- (7) If coverage is issued, the coverage will not be a continuation of any prior coverage.
- (8) The policy being applied for may contain waiting periods for certain benefits listed on the policy Data Page.
- (9) Incorrect or incomplete information on this application may result in voidance of coverage and/or claim denial.
- (10) This completed application, and any supplements or amendments, will be a part of any policy, if issued.
- (11) The broker may only submit the application and initial payment, and may not promise me coverage, modify GRIC's underwriting policy or terms of coverage, or change or waive any right or requirement.
- (12) 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 applicants.
- (13) **THIS IS NOT A MEDICARE SUPPLEMENT POLICY.**
- (14) I have received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

X _____
Proposed Insured's Signature

X _____
Date you signed and read application

IMPORTANT NOTES: No application will be accepted if received by GRIC more than 15 days after the date signed. Altered applications will not be accepted.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL AND/OR VISION 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 or information you have furnished, you intend to lapse or otherwise terminate existing dental and/or vision insurance and replace it with a policy to be issued by Golden Rule Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Conditions which you may presently have, may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits present under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

3. If, after due consideration, 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. Failure to include all material 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, re-read it carefully to be certain that all information has been properly recorded.

Also, if you are issued coverage, carefully check the application again and write to Golden Rule Insurance Company at the address shown at the top of this notice within 10 days if any information is not correct and complete.

The above "Notice to Applicant" was delivered to me on:

Date _____ Applicant's Signature _____

082F-G **Golden Rule Insurance Company's Copy** 0816

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 Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

X _____ X _____
 Signature of Licensed Broker Print Full Name

 Broker Number

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

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

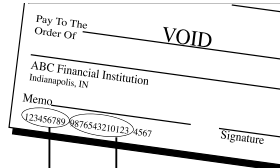
I agree this authorization will remain in effect until you actually receive written notification of its termination from me.

Type of Account: Checking Savings

Nine-digit Routing No. _____

Acct No. _____

053F-G-0816



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

CREDIT CARD AUTHORIZATION — ONLY IF PAYING BY CREDIT CARD

I authorize Golden Rule Insurance Company to bill my American Express/MasterCard/Visa account for the Total Premium for Mode Chosen.*

Type of Card: MasterCard Visa Exp. Date: _____
 American Express Month Year

ZIP Code: _____

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

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Card Number: _____

X _____
 Signature of Authorized User

Charge On _____
 Day

Only select a charge date between the 1st and 28th of the month.

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Date

082F-G

Applicant's Signature

Applicant's Copy

0816

Mail completed application and initial premium to:

Golden Rule Insurance Company
PO Box 31370
Salt Lake City, UT 84131-0370