PLEASE NOTE: THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.

GOLDEN RULE INSURANCE COMPANY

SECTION 1 Application for Supplemental Indemnity Insurance

Applicant(s) Information - Must Be Completed by the Applicant(s)

Please Print In Black Ink

REASON FOR APPLICATION: ☐ New Application ☐ Benefit Change ☐ Add a Dependent ☐ Reinstatement

Policy Number _____
(for reinstatement, additions, or benefit change)

Please list only those persons needing coverage.

Gender	Name (Last, First, M.I.)	Birth Date	Age	DO NOT ESTIMATE Height	DO NOT ESTIMATE Weight
☐ Male ☐ Female	Primary (You)				
☐ Male ☐ Female	Spouse				
☐ Male ☐ Female	Child 1				
☐ Male ☐ Female	Child 2				
☐ Male ☐ Female	Child 3				
☐ Male ☐ Female	Child 4				
☐ Male ☐ Female	Child 5				

If you need to list additional dependents, please use lined paper, sign and date it, and check this box. ☐

Mailing Address

Street (Include Apt.)

City State ZIP

Phone Numbers ( ) Home ( ) Work (optional) ( ) Cell (optional) Email Address

A physical address is required if different than your mailing address. PO Boxes are not accepted as a physical address.

Physical Address

Street (Include Apt.)

City State ZIP

Payor (If not You) Name Email Address

Street City State ZIP

Your Beneficiary: _____ You will be the beneficiary for your spouse.
Name Relationship Age

Requested Effective Date: ____/____/____

SECTION 2

Plan Choices

☐ **Hospital SafeGuard Plan A**
☐ **Hospital SafeGuard Plan B**
☐ **Hospital SafeGuard Premier Plan A**
☐ **Hospital SafeGuard Premier Plan B**

Initial Monthly Payment with Application $ _____

If Quarterly, Initial Monthly Payment with Application x 3 $ _____

SECTION 3

Underwriting Questions – Must be completed

		If Yes, Who?
1. Does any applicant have or is any applicant currently applying for hospital or other fixed indemnity insurance?	☐ Yes ☐ No	
If yes, Who: _____ Company Name: _____	Policy Number: _____	
If yes, Who: _____ Company Name: _____	Policy Number: _____	
If yes, Who: _____ Company Name: _____	Policy Number: _____	
2. Does any applicant intend to replace any existing coverage in force?	☐ Yes ☐ No	
If yes, Who: _____ Company Name: _____	Policy Number: _____	
If yes, Who: _____ Company Name: _____	Policy Number: _____	
If yes, Who: _____ Company Name: _____	Policy Number: _____	
3. Is any applicant currently pregnant, an expectant parent, in the process of adopting a child, or undergoing infertility treatment?	☐ Yes ☐ No	
4. During the past 12 months, has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco and e-cigarettes) or nicotine substitute?	☐ Yes ☐ No	
5. During the past 12 months, has any applicant:		
a. Been confined to a hospital (other than pregnancy), nursing home, mental facility, inpatient rehabilitation, sub-acute facility, or hospice?	☐ Yes ☐ No	
b. Been bedridden, received home health care, or been confined to a wheelchair?	☐ Yes ☐ No	
c. Received medical care from a member of the medical profession for a condition that has yet to be diagnosed?	☐ Yes ☐ No	
d. Been advised to undergo any test (except HIV test), treatment, hospitalization, or surgery which has not yet been completed or for which test results have not yet been received?	☐ Yes ☐ No	
e. Experienced unexplained weight loss of more than 10 pounds?	☐ Yes ☐ No	
f. Received medical advice, treatment, or counseling from a member of the medical profession for schizophrenia, bipolar disorder, or been prescribed anti-psychotic medication?	☐ Yes ☐ No	
g. Been diagnosed with, received medical care or treatment from a member of the medical profession for any disorder of the heart or circulatory system, uncontrolled hypertension/high blood pressure, chest pains, or irregular heart beat?	☐ Yes ☐ No	
6. During the past 5 years, has any applicant been diagnosed with or received medical care from a member of the medical profession for any of the following:		
a. Heart attack, cardiomyopathy, bypass/stents/angioplasty, atrial fibrillation, implant of pacemaker/ defibrillator, heart surgery (including valve replacement or correction), congestive heart failure, stroke/transient ischemic attack (TIA), thrombosis, embolism, or hemophilia?	☐ Yes ☐ No	
b. Any cancer (excluding basal cell or squamous cell skin cancer) or carcinoma in situ?	☐ Yes ☐ No	
c. Chronic obstructive pulmonary disease (COPD) or chronic lung disease, emphysema, or cystic fibrosis?	☐ Yes ☐ No	
d. AIDS, ARC, HIV infection, or any AIDS related condition?	☐ Yes ☐ No	
e. Drug or alcohol abuse or addiction?	☐ Yes ☐ No	
f. Diabetes (except gestational diabetes), organ transplant (or awaiting an organ transplant), chronic kidney disease or disorder (not including stones), chronic liver disease (including cirrhosis, Hepatitis B, or Hepatitis C), Alzheimer's or senile dementia, Systemic lupus erythematosus (SLE), or Parkinson's?	☐ Yes ☐ No	

If you need more space to provide complete and accurate information, please use lined paper, sign and date it, and check this box. ☐

SECTION 4

General Statement of Understanding – Review the completed application and read the section below carefully before signing.

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. This Statement of Understanding section will become part of the application. I understand and agree that:

(1) There will be no benefits for any loss incurred in the first 12 months of coverage due to a preexisting condition.

(2) This application and the initial payment do not give me immediate coverage.

(3) 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 Insurance Company (GRIC).

(4) 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.

(5) If coverage is issued, the coverage will not be a continuation of any prior coverage.

(6) I should not terminate existing coverage until I have accepted the GRIC coverage.

(7) Incorrect or incomplete information on this application may result in voidance of coverage and/or claim denial.

(8) This completed application, and any supplements or amendments, will be a part of any policy or policies, if issued.

(9) The producer 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.

(10) The producer may receive copies of any correspondence about my medical history when correspondence is required.

(11) I must notify GRIC of any medical conditions or treatment arising between the date of this application and the effective date of my coverage.

(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) If GRIC rejects this application, under no circumstances will any benefits be payable. Receipt of money, cashing of my check, or charging my credit card by GRIC does not constitute approval of my application or create GRIC coverage.

(14) I have received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

X _____ X _____

Proposed Insured's Signature — Date signed and read application and product brochure

X _____ X _____

Spouse's Signature — Date signed and read application and product brochure

INDEM-AP-161-GRI-06

Producer 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 Producer — Print Full Name

Producer Number

Payor Information (If other than Proposed Insured)

( ) _____

Contact Number

May 3 2017 12:34:11 pm

Payment

Initial Payment Method With Application – Select One Below

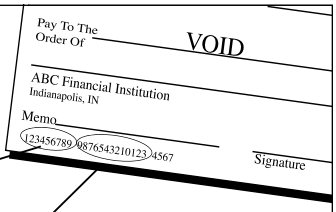
☐ **EFT** — Complete EFT Authorization below (EFT is only available with Monthly Initial Payment)
☐ **Credit Card** — Complete Credit Card Authorization below
☐ **Check** — Made payable to Golden Rule Insurance Company

Ongoing Payments – Select One Below

☐ Monthly EFT
☐ Monthly Credit Card
☐ Quarterly Direct Bill
☐ Semi-Annual Direct Bill
☐ Annual Direct Bill

Electronic Funds Transfer (EFT) and Credit Card payments will be collected at the time of application. If Initial Payment is EFT, Ongoing Payment must be EFT. If you choose Check as your Initial Payment Method, please mail your check with your completed application - checks are deposited upon receipt. Premium will be verified and may be adjusted up or down during the processing of your application.

☐ **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. _____ Account No. _____

Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____ _____
Day Date Signed

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

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.
If quarterly billing requested, the Initial Payment will be for three months.

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

Billing ZIP Code: _____ Card Number: _____

X_____ Charge On _____
Signature of Authorized User Day

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

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

Final Authorizations

Authorization to Obtain and Disclose Nonmedical Information

I authorize Golden Rule Insurance Company's (GRIC) New Business and Medical History Review departments to obtain information that they need to underwrite or verify my application for insurance. Any employer, insurance company, government agency, consumer-reporting agency, or MIB, Inc., formerly known as Medical Information Bureau (MIB) having information about my occupation(s), avocations, driving history, criminal history, or prior insurance coverage for my family or me is authorized to give it to GRIC's New Business and Medical History Review departments.

GRIC may also release this information about my family or me to the MIB or any member company for the purposes described in GRIC's Notice of Privacy Practices.

I (we) have received GRIC's Notice of Privacy Practices.
This authorization shall remain valid for 30 months from the date below.

I (we) understand the following: A photocopy of this authorization is as valid as the original. I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to GRIC. I (we) may request revocation of this authorization by writing to GRIC, as explained in GRIC's Notice of Privacy Practices. GRIC may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization. The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws.

I have read the above: Authorization to Obtain and Disclose Nonmedical Information.

Signed X ___/___/___
Date

X _____
Signature of Primary Applicant (You)

X _____
Signature of Spouse (If to be covered)

051F-G-0816

Authorization to Obtain and Disclose Health Information

I authorize Golden Rule Insurance Company's (GRIC) New Business and Medical History Review departments to obtain health information that they need to underwrite or verify my application for insurance. Any health care provider, pharmacy benefit manager, consumer-reporting agency, MIB, Inc., formerly known as Medical Information Bureau (MIB), or insurance company having any information as to a diagnosis, the treatment, or prognosis of any physical or mental conditions about my family or me is authorized to give it to GRIC's New Business and Medical History Review departments. This includes information related to substance use or abuse.

I understand any existing or future requests I have made or may make to restrict my protected health information do not and will not apply to this authorization, unless I revoke this authorization.

GRIC may release this information about my family or me to the MIB or any member company for the purposes described in GRIC's Notice of Privacy Practices.

I (we) have received GRIC's Notice of Privacy Practices.
This authorization shall remain valid for 30 months from the date below.

I (we) understand the following:

- A photocopy of this authorization is as valid as the original;
- I (we) or my (our) authorized representative may obtain a copy of this authorization by writing to GRIC;
- I (we) may request revocation of this authorization as described in GRIC's Notice of Privacy Practices;
- GRIC may condition enrollment in its health plan or eligibility for benefits on my (our) refusal to sign this authorization;
- The information that is used or disclosed in accordance with this authorization may be redisclosed by the receiving entity and may no longer be protected by federal or state privacy laws regulating health insurers.

I have retained a copy of this authorization.

052F-G-0816

I have read the above: Authorization to Obtain and Disclose Health Information.

Signed X ___/___/___
Date

X _____
Signature of Primary Applicant (You)

X _____
Signature of Spouse (If to be covered)

Mail completed application and initial premium to:

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

Complete if Replacing a Fixed Hospital Indemnity and/or Accident Expense

Notice to Applicant Regarding Replacement of Accident and Health 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, information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness 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 facts which may affect the insurance protection available to you under the new policy.

1. Health 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 of benefits 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 interests 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 concerning your medical/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, re-read it carefully to be certain that all information has been properly recorded.

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

_____

Date

_____

Applicant's Signature

210F-G **Golden Rule Insurance Company's Copy** 0816

May 3 2017 12:34:11 pm

Complete if Replacing a Fixed Hospital Indemnity and/or Accident Expense

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1. Health 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 of benefits 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 interests 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 concerning your medical/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, re-read it carefully to be certain that all information has been properly recorded.

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

_____
Date

_____
Applicant's Signature

210F-G **Applicant's Copy** 0816

TO BE COMPLETED BY PRODUCER ONLY IF PERSONALLY COLLECTING INITIAL PREMIUM PAYMENT.

Conditional Receipt for: _____ Date of Receipt: _____

Proposed Insured: _____ Signature of Secretary: Richard C. Sullivan

Amount Received: _____ Signature of Agent/Broker: _____

THIS FORM LIMITS OUR LIABILITY. NO INSURANCE WILL BECOME EFFECTIVE UNLESS ALL THREE CONDITIONS PRIOR TO COVERAGE ARE MET.
NO PERSON IS AUTHORIZED TO ALTER OR WAIVE ANY OF THE FOLLOWING CONDITIONS. YOUR CANCELLED CHECK WILL BE YOUR RECEIPT.

This conditional receipt does not create any temporary or interim insurance and does not provide any coverage except as expressly provided in the Conditions Prior to Coverage.

Conditions Prior to Coverage (Applicable with or without the Conditional Receipt)

Subject to the limitations shown below, insurance will become effective if the following conditions are met:

1. The application is completed in full and is unconditionally accepted and approved by Golden Rule Insurance Company.
2. The first full premium, according to the mode of premium payment chosen, has been paid on or prior to the effective date, and any check is honored on first presentation for payment.
3. The policy is: (a) issued by Golden Rule Insurance Company exactly as applied for within 45 days from date of application; (b) delivered to the proposed insured; and (c) accepted by the proposed insured.