Please Print in Black Ink

APPLICATION FOR SHORT TERM MEDICAL[SM] INSURANCE
GOLDEN RULE INSURANCE COMPANY — INDIANAPOLIS, INDIANA 46278-1719

PROPOSED INSURED

First | Middle Initial | Last | Height | Weight | Birth Date * | Age | ☐ Male ☐ Female

Resident Physical Address (where you live and pay taxes). PO Boxes are not accepted.

Street (Include Apt.) | City | State | ZIP | ( ) Telephone No.

Mailing Address (if different than Resident Address)

Street (Include Apt.) | City | State | ZIP

Email Address _____

Proposed Insured | Spouse (if to be covered)

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

Dependent's Name (Last, First, M.I.)	Relationship	Height	Weight	Date of Birth*	
	Spouse/Domestic Partner			/ /	☐ M ☐ F
				/ /	☐ M ☐ F
				/ /	☐ M ☐ F
				/ /	☐ M ☐ F
				/ /	☐ M ☐ F
				/ /	☐ M ☐ F

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

		Yes	No
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? ..... **If yes, coverage cannot be issued.**	☐	☐
3.	Have you or has anyone named in Question 1 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:** blood disorders, liver disorders, kidney disorders, chronic obstructive pulmonary disorder (COPD) or emphysema, diabetes, cancer, heart or circulatory system disorders (excluding high blood pressure), Crohn's disease or ulcerative colitis, or alcohol or drug abuse or immune system disorders? ..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy.)	☐	☐
7.	Within the last 5 years, have you or has anyone listed on the application received treatment, advice, medication, or surgical consultation for HIV infection from a doctor or other licensed clinical professional, or had a positive test for HIV infection performed by a doctor or other licensed clinical professional? ..... If yes, state the name of each person: _____ (The person(s) named will not be covered under the policy.)	☐	☐

Oct 31 2017 02:56:46 pm

8. Have you or has any person named in Question 1 had testing performed and has not received results, or been advised by a medical professional to have treatment, testing, or surgery that has not been performed? ..... ☐ ☐
If yes, state the name of each person: _____
(The person(s) named will not be covered under the policy.)

☐ **Short Term Medical[SM] Plus Elite**
☐ **80/20 - $2,000**
☐ **70/30 - $5,000**

☐ **Short Term Medical[SM] Copay**
70/30 - $10,000

☐ **Short Term Medical[SM] Copay Value**
70/30 - $10,000

☐ **Short Term Medical[SM] Plus**
☐ **80/20 - $2,000**
☐ **70/30 - $5,000**

☐ **Short Term Medical[SM] Value**
☐ **70/30 - $5,000**
☐ **70/30 - $10,000**

DEDUCTIBLE: ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $10,000

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

DAYS OF COVERAGE: _____

OPTIONAL BENEFITS:

☐ Supplemental Accident Benefit: ☐ $1,000 ☐ $1,500 ☐ $2,500 ☐ $5,000 ☐ $10,000

☐ Per Cause Deductible

PRESCRIPTION DRUGS *(You may only choose one.)*:

☐ Prescription Drug - Add 4 Tier Rx Coverage *(Available with Short Term Medical[SM] Copay Plan only)*

☐ Prescription Drug - Add a Generic $20 Rx Copay *(Available with all Plans except Short Term Medical[SM] Value)*

☐ Prescription Drug - Remove Rx Coverage *(Available with Short Term Medical[SM] Copay Plan only)*

☐ Prescription Drug - Add Rx Coverage *(Available with Short Term Medical[SM] Copay Value Plan only)*

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 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 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. 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.

By signing below, I also acknowledge that I have received a copy of the Outline of Coverage, as well as a Disclosure Notice.

X _____ X _____
Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child — Date you signed and read application

X _____ Ann Gridley 6232325
Spouse (if to be covered) — Licensed Agent or Broker (Please Print) — Individual Producer #

Important Notes:

- **"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.**
- **Altered applications will not be accepted.**
- **Coverage is available for 30 to 360 days. The policy does not exceed 360 days. The policy cannot be renewed.**
- **This policy does not qualify as minimum essential health coverage under the federal Affordable Care Act. Even if you have this coverage you still may be subject to the federal tax assessed against individuals without minimum essential coverage.**

PAYMENT OPTIONS: SINGLE OR MONTHLY (Initial Payment Method Required With Application)

Electronic Funds Transfer (EFT) and Credit Card payment will be collected at the time of application. If coverage is not issued, we will refund the money we collected, minus the nonrefundable application fee.

☐ **Single Payment** (one single payment for all days of coverage chosen):

- ☐ **EFT $ Amount** _____ Includes $20 nonrefundable application fee.
  Please complete the EFT Authorization below.
- ☐ **Credit card $ Amount** _____ Includes $20 nonrefundable application fee.
  Please complete the Credit Card Authorization below.
- ☐ **Check or money order $ Amount** _____ Includes $20 nonrefundable application fee.
  Please mail your check or money order, payable to Golden Rule Insurance Company, with your application. Checks are deposited upon receipt.

OR

☐ **Monthly Payment:** (Based on 30 days of coverage.) Final Premium Payment may be less due to less than 30 days of coverage remaining.

Initial Payment ☐ EFT (Ongoing payment must be EFT.) ☐ Credit Card ☐ Check or money order
Please mail your check or money order, payable to Golden Rule Insurance Company, with your application. Checks are deposited upon receipt.

$ Amount _____ Initial Payment amount (shown) includes a one-time $20 nonrefundable application fee.

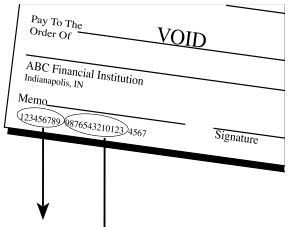
Ongoing Payments (Choose one)

- ☐ **Electronic Funds Transfer** (EFT) (No billing fee.)
  Ongoing monthly EFT payments will not include the $20 application fee.
- ☐ **Credit Card** (No billing fee.)
  Ongoing monthly Credit Card payments will not include the $20 application fee.

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION — COMPLETE 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

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.

CREDIT CARD AUTHORIZATION — COMPLETE ONLY IF PAYING BY CREDIT CARD

Credit Card Authorization ☐ Visa ☐ MasterCard ☐ American Express

I authorize Golden Rule Insurance Company to charge my Visa/MasterCard/American Express account for the Single Payment or Monthly Payment above.

Account No. _____ Expiration Date (Mth/Yr) _____/_____ Billing ZIP Code _____ X _____ Signature of Authorized User

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

Charge On _____ (29th, 30th, 31st not available)
Day

Oct 31 2017 02:56:46 pm

PAYOR INFORMATION (If other than Proposed Insured)

Payor: _____
Name Email Address

_____
Street City State ZIP

( ) _____
Contact Number

OREGON INDIVIDUAL HEALTH INSURANCE POLICY DISCLOSURE STATEMENT

By signing below, I acknowledge that I have received a copy of the Disclosure Statement.

X _____ X _____
Proposed Insured's Signature Date

Oct 31 2017 02:56:46 pm

OREGON INDIVIDUAL HEALTH INSURANCE POLICY DISCLOSURE STATEMENT

Ann Gridley

(Broker Name and Address)

completed this questionnaire on _____ for
(Date)

_____

(Applicant's Name and Address)

describing the individual Short Term Medical Expense Policy plans issued on policy forms IST6.0-G, etc.

These short term policies are underwritten by Golden Rule Insurance Company, 7440 Woodland Drive, Indianapolis, Indiana 46278-1719.

NOTICE: This disclosure statement answers questions consumers often ask about health insurance coverage and costs. It highlights some of the important issues that frequently affect consumers. It is intended for your use whether you are purchasing health insurance for the first time or whether you are replacing your existing coverage.

Are you considering replacing your current coverage?
Before you replace your current policy with another, you should review both policies in order to determine whether replacement is in your best interests. The new coverage may be different in important respects. You should be aware of these differences, whether they are temporary or permanent. If you obtained your current policy from another broker, agent, or a representative of another company, be sure to ask that broker, agent, or representative any questions you may have about that policy.

Are you considering adding to your current coverage?
The Golden Rule short term medical plans are not issued to persons who have current other medical coverage that they are not replacing.

Questions? Ask for help.
If you have any questions that are not answered by this disclosure statement, be sure to ask your broker.

Read your policy!
If you purchase one of Golden Rule's short term medical policies, read your policy carefully as soon as you receive it. Because it is an individual policy, you will have an opportunity to send it back and obtain a premium refund.

Fill out your application carefully!
Be sure to fill out all portions of your application completely and truthfully. If misstatements are made or information about your health is omitted from the application, we may void the policy or deny your claims. If your age is misstated, the amounts payable on claims may be reduced.

We hope this disclosure statement will help you with your insurance purchase. However, please note that this disclosure statement is not intended to be a part of the policy and that only the actual policy issued by us is final and binding.

GENERAL QUESTIONS AND ANSWERS

1. *Does Golden Rule Insurance Company have a list of doctors or hospitals, or both, under contract that are considered "preferred" or "participating?"*
   Yes. Golden Rule Insurance Company uses UnitedHealthcare's network of providers.

2. *May I use doctors or hospitals that are not on the list?*
   Yes, but you will likely pay more for services received from providers that are not on the list.

3. *Will I save money by using the doctors or hospitals on the list instead of others?*
   Yes, you will usually save money by using the providers on the list.

4. *Will doctors and hospitals on the list accept benefits paid under the policy as full payment and not bill me for the balance (other than for deductibles, coinsurance, and copayments)?*
   Yes. Providers on the list have agreed to accept benefits paid under the policy as full payment and are not allowed to bill you for the balance, except for deductibles, coinsurance, and copayments.

5. Pregnancy Benefits:

   (a) *What are the policy's benefits and limitations with respect to pregnancy?*
   The Golden Rule short term plans do not cover expenses related to normal pregnancy and childbirth.

   (b) *Will the offered policy cover a pregnancy without complications if the pregnancy is in existence at the time the policy is issued?*
   No.

6. *If I replace my current policy and there is no lapse or gap in coverage, will my enrollment under the old policy count toward meeting any waiting periods under the new policy, such as for preexisting condition limitations?*
   No. Short term medical expense policies do not count as creditable coverage. Any waiting periods satisfied under your current policy do not count toward a short term policy.

7. *Will expenses I incurred under my current policy during the current policy year be credited to the new policy's deductible(s)?*
   No.

8. *If I have a health condition existing when the offered policy is issued, will that condition be covered as of the date the new policy is issued?*
   No. The Golden Rule short term plans do not cover preexisting conditions.

9. *Does the policy contain any dollar limitations on specific benefits?*
   Yes. All plans have a maximum benefit limit of $1,000,000. Some of the plans have dollar limits on expenses for treatment of mental disorders, substance abuse, and spine and back disorders. Please see the brochure for more information.

CONSENT TO RECEIVE ELECTRONIC RECORDS AND TO CONDUCT TRANSACTIONS ELECTRONICALLY

By submitting this consent form or a health insurance application or HMO enrollment form, you hereby consent to presentation, delivery, storage retrieval and transmission of "Communications" related to "Our Transaction" as electronic records instead of in paper form.

For the purposes of this form, "Our Transaction" means the entirety of the business relationship between you and us. "Communications" includes, but is not limited to:

1. Your application or enrollment form, including subsequent amendments;
2. Information related to Our Transaction that we are required to provide or make available in writing such as privacy notices or fraud warnings;
3. Documents related to Our Transaction such as policy, certificate, or evidence of coverage forms, claim forms, explanation of benefit forms, premium notices, or other administrative forms (to the extent permitted by applicable law);
4. Any emails, faxes, recorded telephone calls, or other electronic transmissions of information between you and us and an insurance producer contracted with us, or between us and any third party.

Subject to our obligations to protect your privacy, we may, at our sole discretion, post Communications on a website (in which case they will be sent or received, as the case may be, regardless of whether or not we own, operate or control the website). Or send them in or attached to an email. You must promptly tell us about any change to your electronic or physical mailing address, or other contact information.

You acknowledge that you can receive or access Communications because you have the following:

- A telephone
- A computer and printer
- A device or computer program for listening to audio CDs, mp3, WAV or other common computer audio files
- An Internet browser
- Access to the Internet
- A valid email address
- Adobe Acrobat Reader or other sufficient PDF reader

You can request a free copy of any Communications, or withdraw your consent to receive electronic Communications at any time by sending a written request to:

Policy Administration
PO Box 31372
Salt Lake City, UT 84131-0372

☐ I hereby consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. All of the Communications between the time you submit your consent and withdraw your consent will remain valid and binding on both you and us notwithstanding your withdrawal.

☐ I hereby DO NOT consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. If you do not consent, we will conduct all future business with you in paper form.

X _____
Primary Applicant *(You)*

X _____
Parent/Guardian *(if you are a minor)* Relationship

_____
Primary Applicant *(You)* Email Address

X _____
Parent/Guardian *(if you are a minor)* Email Address

_____
Date

_____
Policy ID Number