

APPLICATION FOR DENTAL/VISION INSURANCE
GOLDEN RULE INSURANCE COMPANY — INDIANAPOLIS, INDIANA

PLEASE PRINT IN BLUE INK

APPLICANT(S) INFORMATION

PROPOSED INSURED:

First Name Middle Initial Last Name Birth Date: Month Day Year Age Gender

Male Female

Mailing Address:

Street (Include Apt.)
City State ZIP

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

Physical Address:

Street (Include Apt.)
City State ZIP

Phone Numbers: Home Other Best number and times to call E-mail Address

DEPENDENTS: List below any dependents to be covered under the policy.

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

PAYOR:

(If not You): Name E-mail Address
Street City State ZIP

- 1. Do you or does any applicant now have dental insurance that will not terminate prior to the requested effective date?
2. If you are applying for vision insurance, do you or does any applicant now have vision insurance that will not terminate prior to the requested effective date?
3. Are you or any dependent intending to replace in force dental or vision (if applicable) insurance?



REQUESTED EFFECTIVE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

(See Statement of Understanding section.)

Plan Choices:  UnitedHealthcare Dental Premier<sup>SM</sup>  UnitedHealthcare Dental Value<sup>SM</sup> (if available)

OPTIONAL:  UnitedHealthcare Vision

Payment Mode:  Monthly  Quarterly  Semi-annual  Annual

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

Ongoing Payments:  Monthly EFT  Direct Bill  List Bill (include forms; \$25 monthly admin. fee per list bill group)

**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) 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; (c) if coverage is issued, the coverage will not be a continuation of any prior coverage; and (d) the policy being applied for may contain waiting periods for certain benefits listed on the policy Data Page. 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.

X \_\_\_\_\_ X \_\_\_\_\_ X \_\_\_\_\_  
Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child State where you signed this application Date you signed and read application

X \_\_\_\_\_ X \_\_\_\_\_  
Licensed Agent or Broker (Please print.) Individual Producer Number

**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.**

DV-AP-130-06

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**NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL 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 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. 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.

2. 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

**Golden Rule's Copy**

722D-G

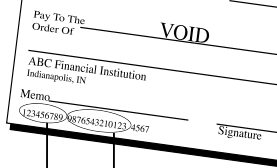
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**CONTINUE WITH PAYMENT INFORMATION ON NEXT PAGE**

**Mail completed application to:**  
Golden Rule Insurance Company  
**DENTAL APPLICATION**  
PO Box 68994  
Indianapolis, IN 46268-0994

**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.

Acct No.

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

E-mail Address

**INITIAL PAYMENT CREDIT CARD AUTHORIZATION**

I authorize Golden Rule to bill my MasterCard/Visa account for the Total Premium for Mode Chosen.\*

Card Number:

Type of Card:  MasterCard  Visa Exp. Date:    
Month Year

X

Signature of Authorized User

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

**CALCULATE YOUR PREMIUM**

**1 CONNECTICUT DENTAL BASE RATES**

|  | 1 Person | 2 People | 3+ People |
|--|----------|----------|-----------|
| UnitedHealthcare <i>Dental Premier</i> Statewide | 42.48    | 84.11    | 148.68    |
| UnitedHealthcare <i>Dental Value</i> Statewide   | 25.52    | 50.53    | 89.32     |

**2 TREND FACTORS**

| Effective Dates               | Factor |
|-------------------------------|--------|
| July through September 2009   | 1.045  |
| October through December 2009 | 1.060  |
| January through March 2010    | 1.075  |
| April through June 2010       | 1.090  |

**3 CONNECTICUT VISION RATES**

|           |      |       |       |
|-----------|------|-------|-------|
| Statewide | 9.00 | 16.00 | 24.00 |
|-----------|------|-------|-------|

**4 PAYMENT MODE FACTORS**

| Modes       | Factor |
|-------------|--------|
| Monthly     | 1      |
| Quarterly   | 3      |
| Semi-annual | 6      |
| Annual      | 12     |

**PREMIUM CALCULATION**

|   |   |                      |
|---|---|----------------------|
| Dental Base Rate for Plan Chosen <b>1</b> . . . . . |   | <input type="text"/> |
| Trend Factor <b>2</b> . . . . .                     | x | <input type="text"/> |
| Subtotal . . . . .                                  | = | <input type="text"/> |
| Vision Rate <b>3</b> . . . . .                      | + | <input type="text"/> |
| Subtotal . . . . .                                  | = | <input type="text"/> |
| Payment Mode Factor <b>4</b> . . . . .              | x | <input type="text"/> |
| <b>Premium for Mode Chosen*</b> . . . . .           | = | <input type="text"/> |

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

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Date

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Applicant's Signature

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