

Please Print  
in Blue Ink.

APPLICATION FOR SHORT TERM MEDICAL<sup>SM</sup> INSURANCE  
GOLDEN RULE INSURANCE COMPANY — LAWRENCEVILLE, ILLINOIS 62439

THIS PLAN IS ISSUED ON AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN.

PROPOSED  
INSURED

First Middle Initial Last

Birth Date \*

Age

Male  
Female  
Sex

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 3 columns: Dependent's Name (Last, First, M.I.), Relationship to You, Date of Birth\*

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

- 2. Have you or any person named on this application been covered by a previous short term policy with Golden Rule within the last 30 days?
3. Are you or is any family member (whether or not named in this application) an expectant mother or father?
4. Have you or has anyone named above been declined for insurance due to health reasons?
5. 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?
6. 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?
7. 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, emphysema, diabetes, cancer, heart or circulatory system disorders (including high blood pressure), alcohol or drug abuse or immune system disorders, including HIV infection?

DEDUCTIBLE: \$ 250 \$ 500 \$ 1,000 \$ 1,500 \$ 2,500
MONTHS OF COVERAGE: 1 MO. 2 MO. 3 MO. 4 MO. 5 MO. 6 MO.
REQUESTED EFFECTIVE DATE: / /

STATEMENT OF UNDERSTANDING

I have read this application and represent that the information shown on it is true and complete to the best of my knowledge and belief. 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.

Signature lines for Proposed Insured's Signature or Parent/Legal Guardian, State where you signed this application, Date you signed and read application, Licensed Agent or Broker, Individual Producer #

This policy excludes coverage for conditions for which medical advice, diagnosis, care, or treatment was recommended or received during the twenty-four months immediately preceding the effective date of coverage.

Important Note: "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.

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

Payor:

Name E-mail Address

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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 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 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.

X

Account No. Expiration Date Signature of Authorized User

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

**OR**

**Monthly Payment: Electronic Funds Transfer (EFT)** (no billing fee): **\$ Amount**  (Total Initial Payment on reverse. First month amount (shown) includes a one-time \$20 application fee.) Additional monthly EFT payments will be \$20 less. For this method of payment, you must complete the EFT Authorization below.

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

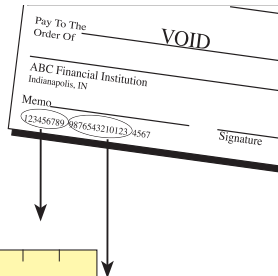
I (we) hereby authorize Golden Rule to initiate debit entries to the account indicated below. I also authorize the named financial institution to debit the same to such account.

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

E-mail 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.