

# Gemini Group Inc.

## Application Instructions For Golden Rule

1. Print all pages of the application including instructions.
2. Complete all questions and sections of the application.
3. Complete the fax cover letter on the next page and fax to Gemini Group Inc. for review along with the completed application. If you do not have access to a fax machine, send the completed application to Gemini Group Inc. along with the required first month's payment.

### HELPFUL TIPS:

Here is a checklist of a few things that are commonly overlooked and are mandatory in processing your application.

- Indicate your requested effective date.
- Select your preferred billing method.
- Sign and date the application.

### IMPORTANT:

If you have requested that your monthly premium be deducted automatically from your checking account, you must attach a voided check to the area provided and also complete, sign, and date the authorization form.

Don't forget to **enclose the initial premium and FACT dues check made payable to "FACT"(does not apply to CT, DE, GA, and LA).**

Mail completed application and check to:

**Gemini Group Inc.**  
**Attn: New Enrollment**  
**789 Sherman Str**  
**Suite 400**  
**Denver, CO 80203**

Gemini Group Inc. will review your application for completeness and accuracy before we submit it to Golden Rule for processing. This may reduce the approval time because they cannot process unclear or incomplete applications until the missing information has been gathered.

Please contact us if you have any questions regarding the application or the application process. You may reach us at (303) 757-1234 or e-mail us at [dan.jones@geminigrp.com](mailto:dan.jones@geminigrp.com).

# Gemini Group Inc.

## Application Process FAX COVER LETTER

(Please ignore this form if you do not have access to a fax machine.)

**\*\*Please FAX this cover letter with the completed application to:**

**Gemini Group Inc.**

**FAX# (303) 861-8147**

Dear Gemini Group Inc.,

Please accept my completed insurance application for submittal and contact me to confirm receipt of this application

Name \_\_\_\_\_

E-mail \_\_\_\_\_

Date \_\_\_\_\_

Time \_\_\_\_\_



Please contact me at this phone number \_\_\_\_\_ after you have reviewed my application for completeness and accuracy.



I will contact Gemini Group Inc. at (303) 757-1234 to verify receipt of my application.

**\*\*I understand that Gemini Group Inc. will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to Gemini Group Inc.. I will mail the original signed application to :

**Gemini Group Inc.**

**Attn: New Enrollment**

**789 Sherman Str**

**Suite 400**

**Denver, CO 80203**

I will send the original application as soon as I have been contacted by Gemini Group Inc. with confirmation that my application has been received by fax and reviewed for completeness.



**COVERAGE INFORMATION**

11. Requested Effective Date: \_\_\_/\_\_\_/\_\_\_ Requested Health Class: Primary:  Preferred  Standard  Tobacco (if question 30 is yes)  
 Plan includes Preferred Network; if not wanted, check here  Spouse:  Preferred  Standard  Tobacco (if question 30 is yes)  
 Network Name: \_\_\_\_\_

<b>Copay Plans</b>	<input type="checkbox"/> Copay Select <sup>SM</sup>	<input type="checkbox"/> \$ 500	<b>HSA Plans</b>	Single	Family	<b>High Deductible</b>	<input type="checkbox"/> \$ 500 (Saver 80 only)
	<input type="checkbox"/> \$1,000	<input type="checkbox"/> \$1,500		<input type="checkbox"/> \$1,050	<input type="checkbox"/> \$ 2,100		<input type="checkbox"/> Plan 100 <sup>®</sup>
	<input type="checkbox"/> \$1,500	<input type="checkbox"/> \$2,500	<input type="checkbox"/> HSA Saver <sup>®</sup>	<input type="checkbox"/> \$1,800	<input type="checkbox"/> \$ 3,650	<input type="checkbox"/> Plan 80 <sup>SM</sup>	<input type="checkbox"/> \$1,500 (Saver 80 only)
	<input type="checkbox"/> Copay Saver <sup>SM</sup>	<input type="checkbox"/> \$2,000		<input type="checkbox"/> \$2,700	<input type="checkbox"/> \$ 5,450	<input type="checkbox"/> Saver 80 <sup>SM</sup>	<input type="checkbox"/> \$2,500
				<input type="checkbox"/> \$3,500	<input type="checkbox"/> \$ 7,500		<input type="checkbox"/> \$3,500
				<input type="checkbox"/> \$5,000	<input type="checkbox"/> \$10,000		<input type="checkbox"/> \$5,000
<b>Optional</b>	<input type="checkbox"/> Term Life Benefit		<b>Optional</b>	<input type="checkbox"/> Term Life Benefit		<b>Optional</b>	<input type="checkbox"/> Term Life Benefit
	<input type="checkbox"/> Preventive Care (Not Available with Copay Select)			<input type="checkbox"/> Preventive Care			<input type="checkbox"/> Preventive Care
	<input type="checkbox"/> Supplemental Accident			<input type="checkbox"/> Hospital Indemnity Rider			<input type="checkbox"/> Supplemental Accident
	<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 Maximum Maternity						<input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 Maximum Maternity
							<input type="checkbox"/> Prescription Drug Card (Not Available with Saver 80)

**BILLING (or attach health insurance quote)**

12. Initial Payment With Application  
 Check  P.A.C. (EFT with on-line app. only)  Credit Card →

Ongoing Payments  
 Monthly P.A.C. (EFT)  Quarterly Direct Bill

FACT Dues \$ 3.00

Base Premium Amount + \_\_\_\_\_

Term Life Benefit + \_\_\_\_\_ Optional

Preventive Care + \_\_\_\_\_ Optional

Supplemental Accident + \_\_\_\_\_ Optional

Maternity Benefit + \_\_\_\_\_ Optional

Prescription Drug Card + \_\_\_\_\_ Optional

HSA Deposit + \_\_\_\_\_ \$25 Monthly Minimum (only with HSA)

**Total Monthly Payment = \$ \_\_\_\_\_**

One-Time HSA Set-Up Fee + \_\_\_\_\_ \$10 only with HSA

One-Time HSA Indemnity Rider + \_\_\_\_\_

**Initial Payment = \$ \_\_\_\_\_** Make check payable to "FACT:"

**Initial Payment Credit Card Authorization**

I authorize FACT or Golden Rule to bill my Visa/MasterCard account for the Initial Payment. **If quarterly billing requested, the Initial Payment will be for three months plus any one-time costs.**

Type of Card:  MasterCard  Visa Expiration Date: \_\_\_\_\_  
 Month \_\_\_\_\_ Year \_\_\_\_\_

Security Code \_\_\_\_\_ (last 3 digits in signature line)

Name as Printed on Card \_\_\_\_\_

Billing Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Card Number \_\_\_\_\_

X \_\_\_\_\_  
 Signature of Authorized User

**Total Monthly Payment = \$ \_\_\_\_\_** → **If Quarterly** → **X3 = \$ \_\_\_\_\_** **Total Quarterly Payment**

One-Time HSA Set-Up Fee + \_\_\_\_\_ One-Time HSA Set-Up Fee

One-Time HSA Indemnity Rider + \_\_\_\_\_ One-Time HSA Indemnity Rider

**Initial Payment = \$ \_\_\_\_\_** **Initial Payment** ←

**OTHER COVERAGE**

13. Within the last 90 days, has any applicant been covered by any type of medical insurance? If yes, complete chart below. Yes  No   
 Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced (see (6) above the signature lines).

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Is this to be replaced?	Termination Date

14. Will the term life benefit replace any existing life insurance? Company Name \_\_\_\_\_ Policy # \_\_\_\_\_ Yes  No

15. Has any applicant ever had an application or policy, voided, declined, postponed, rated, or charged an extra premium, or had coverage modified (including medical exclusion riders) by any health or life insurer? (If yes, list name and give details.) Yes  No   
 Person: \_\_\_\_\_ Company: \_\_\_\_\_ Action Taken: \_\_\_\_\_  
 Date: \_\_\_\_\_ Reason for Action: \_\_\_\_\_

16. Has any applicant previously applied for, or been covered by, Golden Rule? Yes  No   
 If yes, who? \_\_\_\_\_ Policy/Certificate # \_\_\_\_\_

It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado Division of Insurance within the Department of Regulatory Agencies.

**DRIVING**

17. In the last 24 months, has any applicant participated in driving any type of motorcycle? Yes No
- If yes, please answer the following questions:**
- a. Name of applicant(s)? \_\_\_\_\_ Yes No
- b. Does the applicant have a valid motorcycle license? Yes No
- c. Within the last 24 months, has the applicant had his/her license suspended or revoked? Yes No
- d. Within the last 24 months, has the applicant, while operating a motor vehicle, been involved in an accident or received a moving violation? If yes, provide details in "Medical History Details." Yes No

**MEDICAL HISTORY -- FOR ALL APPLICANTS**

IMPORTANT! PLEASE PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS."

- |                                                                                                                                                           | Yes                      | No                       |                                                                                                                                                                                                                         | Yes                      | No                       |
|-----------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|--------------------------|--------------------------|
| 18. Is any family member (whether or not named in this application) pregnant or an expectant mother or father? .....                                      | <input type="checkbox"/> | <input type="checkbox"/> | 24. <b>In the last 10 years, has any applicant:</b>                                                                                                                                                                     |                          |                          |
| 19. Do any applicants, other than dependent children, <b>not</b> read, write, speak, and understand the English language? .....                           | <input type="checkbox"/> | <input type="checkbox"/> | a. had a complicated pregnancy or delivery? .....                                                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have an adoption pending? .....                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> | b. tested positive for antibodies to the HIV virus? .....                                                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> |
| 21. <b>In the last 6 months</b> , has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind? ..... | <input type="checkbox"/> | <input type="checkbox"/> | c. been hospital confined, had surgery, or discussed surgery? .....                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. <b>Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:</b>    |                          |                          | 25. <b>In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:</b>                                                        |                          |                          |
| a. gallbladder? .....                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> | a. heart or circulatory system? .....                                                                                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. pancreas or liver? .....                                                                                                                               | <input type="checkbox"/> | <input type="checkbox"/> | b. nervous system? .....                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| c. joints or spine? .....                                                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> | c. digestive system? .....                                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| d. kidney? .....                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> | d. muscular or skeletal system? .....                                                                                                                                                                                   | <input type="checkbox"/> | <input type="checkbox"/> |
| e. eyes, ears, or nose? .....                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | e. respiratory system? .....                                                                                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> |
| f. mouth, throat, or jaw? .....                                                                                                                           | <input type="checkbox"/> | <input type="checkbox"/> | f. male or female reproductive system, including infertility? .....                                                                                                                                                     | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. <b>In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:</b>                                       |                          |                          | g. urinary system? .....                                                                                                                                                                                                | <input type="checkbox"/> | <input type="checkbox"/> |
| a. high blood pressure? .....                                                                                                                             | <input type="checkbox"/> | <input type="checkbox"/> | h. thyroid, breast, or other glands? .....                                                                                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| b. chest pain? .....                                                                                                                                      | <input type="checkbox"/> | <input type="checkbox"/> | 26. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any other disease, disorder, injury, or adverse finding, or had any adverse or abnormal test results? ..... | <input type="checkbox"/> | <input type="checkbox"/> |
| c. headaches? .....                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | 27. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more? .....                                                                                                              | <input type="checkbox"/> | <input type="checkbox"/> |
| d. paralysis? .....                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | 28. In the last 5 years, has any applicant had any indication, diagnosis, or treatment of an alcohol or drug dependency, problem, or abuse; or any alcohol- or drug-related arrest? .....                               | <input type="checkbox"/> | <input type="checkbox"/> |
| e. arthritis? .....                                                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> | 29. Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks per week? .....                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |
| f. convulsions or epilepsy? .....                                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> | If yes, show who and how many drinks per week in "Medical History Details" (one drink equals: 12 oz. of beer; 4 oz. of wine; 1 oz. of hard liquor).                                                                     |                          |                          |
| g. elevated cholesterol? .....                                                                                                                            | <input type="checkbox"/> | <input type="checkbox"/> | 30. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, mark "Tobacco" in Question 11.) .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| h. sexually transmitted disease? .....                                                                                                                    | <input type="checkbox"/> | <input type="checkbox"/> | 31. List in "Medical History Details" any additional doctors or other health care professionals that any applicant has consulted with or been treated by in the last 5 years, and give full details.                    |                          |                          |
| i. cancer? .....                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                         |                          |                          |
| j. diabetes or sugar in the blood or urine? .....                                                                                                         | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                         |                          |                          |
| k. stroke? .....                                                                                                                                          | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                         |                          |                          |
| l. Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness? .....                                                                | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                         |                          |                          |
| m. tumor, cyst, polyp, lump, or growth of any kind? .....                                                                                                 | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                         |                          |                          |
| n. mental, emotional, or behavioral disorder? .....                                                                                                       | <input type="checkbox"/> | <input type="checkbox"/> |                                                                                                                                                                                                                         |                          |                          |



**MONTHLY P.A.C. AUTHORIZATION -- ONLY IF PAYING BY MONTHLY P.A.C.**

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

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

Routing No. \_\_\_\_\_

Checking Account No. \_\_\_\_\_

**Include Voided BLANK check!**

Financial Institution's Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Draft On \_\_\_\_\_ Day \_\_\_\_\_ (Date Signed)

X \_\_\_\_\_  
(Signature of Account Holder)

**HEALTH INSURANCE CERTIFICATION AND AUTHORIZATION TO OBTAIN AND DISCLOSE NONMEDICAL INFORMATION**

This insurance coverage is not designed nor marketed as employer-provided insurance. This coverage does not comply with all your state's small-employer group health insurance laws. Therefore, this plan cannot be used, now nor at some future date, by you or an employer to provide insurance for employees.

I certify that:

- (a) my employer is not contributing any part of the premium, directly or through wage adjustments or other means of reimbursement;
- (b) neither I nor my dependents intend to treat this insurance as part of a plan or program under section 106, 125, or 162 of the U.S. Internal Revenue code; and
- (c) this plan was not marketed to me through my employer's place of business.

By signing below, I certify that I understand that I am applying for personal health insurance that may never be used as employer-provided insurance.

063B-799

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain information that they need to underwrite or verify my application for insurance. Any person,

employer, insurance company, consumer-reporting agency, or the Medical Information Bureau (MIB) having nonmedical information about my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments.

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

I (we) have received Golden Rule's Notice of Information 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 Golden Rule. I (we) may request revocation of this authorization by writing to Golden Rule, as explained in Golden Rule's Notice of Information Practices. Golden Rule 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: Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.**

Signed X \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ at \_\_\_\_\_ City \_\_\_\_\_ State

X \_\_\_\_\_  
Signature of Primary Applicant (You)

X \_\_\_\_\_  
Signature of Parent/Guardian (If You are a minor)

X \_\_\_\_\_  
Signature of Spouse (If to be covered)

**AUTHORIZATION TO OBTAIN AND DISCLOSE HEALTH INFORMATION**

I authorize Golden Rule Insurance Company's Insurance Administration and Claims Departments to obtain health information that they need to underwrite or verify my application for insurance. Any health care provider, the 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 Golden Rule's Insurance Administration and Claims 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.

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

I (we) have received Golden Rule's Notice of Information 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 Golden Rule;
- I (we) may request revocation of this authorization as described in Golden Rule's Notice of Information Practices;
- Golden Rule 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.

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

Signed X \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ at \_\_\_\_\_ City \_\_\_\_\_ State

X \_\_\_\_\_  
Signature of Primary Applicant (You)

X \_\_\_\_\_  
Signature of Parent/Guardian (If You are a minor)

X \_\_\_\_\_  
Signature of Spouse (If to be covered)

**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 Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

I agree with the answer given for Question 14, "Will the term life benefit replace any existing life insurance?" (If the response shown for Question 14 does not reflect your understanding, please check this box and attach an explanation. )

X \_\_\_\_\_  
Signature of Licensed Broker  
443849492  
Broker Number

X Daniel Jones  
Print Full Name

**HEALTH SAVINGS ACCOUNT (HSA) APPLICATION (only if opening an HSA with Exante)**

By signing below, I acknowledge that:

**Per the USA Patriot Act:** To help the government fight the funding of terrorism and money laundering activities, federal law requires all financial institutions to obtain, verify, and record information that identifies each person who opens an account. When you open the account, we will ask for your name, street address, date of birth, and other information that will allow us to identify you. We may also ask to see your driver's license or other identifying documents.

- I wish to establish an HSA with Exante Bank as custodian.
- I understand and agree that my HSA will be opened under and governed by Exante Bank's Custodial and Deposit Agreement. Terms of this Agreement will be binding on me unless I close my account within 30 days. This document will be sent to me when my account is opened, along with Exante Bank's Privacy Policy and Schedule of Fees and Charges.
- I authorize Exante Bank to provide information about my HSA, including my account number, to Golden Rule, and those acting on behalf of Golden Rule or Exante Bank (if applicable), in connection with the establishment and maintenance of my HSA.
- I acknowledge that Golden Rule and all others acting on behalf of Golden Rule (if applicable), may provide information on my behalf to establish and maintain my HSA.
- I understand my monthly account statements will be made available to me electronically. I agree to notify Exante Bank if I wish to have statements mailed to my home address.
- If I have filled out the information to request an additional debit card, I hereby request Exante Bank to issue a debit card on my account to the person indicated and I acknowledge I will be liable for the use of the debit card by the Authorized User.
- I certify that the information provided in this application is true and complete.

Have you, within the last 6 months, been covered under another health insurance plan?  Yes  No  
Has your spouse?  Yes  No

**REQUEST FOR AN ADDITIONAL DEBIT CARD (OPTIONAL)**

Authorized User's \_\_\_\_\_  
First Name Middle Initial

Authorized User's \_\_\_\_\_  
Last Name

Authorized User's \_\_\_\_\_  
Date of Birth

Authorized User's \_\_\_\_\_  
Social Security No.

X \_\_\_\_\_  
Signature of Primary Applicant  
Primary Applicant's  
Social Security Number \_\_\_\_\_

155X-0606

**REVIEW BEFORE MAILING THE APPLICATION**

**Be sure:**

- To read the current product brochure before completing the application for insurance.

**Note:**

- If you were previously insured by UnitedHealthcare, you must still fully complete this application accurately. Our underwriters do not have access to UnitedHealthcare underwriting and claims files.
- Broker must be licensed with Golden Rule in state where application is signed AND state where applicant resides.
- Coverage is not available if:
  - any family member is currently pregnant; or
  - the applicant has not resided in the U.S. for the last 12 consecutive months.
- Altered applications will not be accepted.
- Any person who knowingly presents false, incomplete, or misleading information in an application for insurance may be committing insurance fraud.

- The applicant will be notified of the actions taken within 45 days after the date of the application, or be given the reason for delay.
- There is no coverage until approved in writing by Golden Rule.
- **P.O. Boxes are not accepted as a Primary Resident Address.**
- **Applications received by Golden Rule more than 15 days after the signed date will not be accepted.**

**Mail the Application and Related Forms Packet to the address below.**

**Be sure to include the following:**

- Health insurance quote.
- Initial payment check made payable to "FACT"
- P.A.C. authorization and voided check (if paying monthly).

**Mail to:** Golden Rule Insurance Company  
HEALTH APPLICATION  
712 Eleventh Street  
Lawrenceville, Illinois 62439-2395