

Please Print
in Black Ink

APPLICATION FOR SHORT TERM MEDICAL INSURANCE
GOLDEN RULE INSURANCE COMPANY -- LAWRENCEVILLE, ILLINOIS 62439

Any person who knowingly and willingly presents a false or fraudulent claim for payment of a loss or benefit or who knowingly and willfully presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

PROPOSED INSURED [] Male [] Female
[] First [] Middle Initial [] Last [] Birth Date [] Age [] Sex

RESIDENT ADDRESS [] Street [] City [] State [] ZIP [] Telephone No.

1. Are any of your dependents to be covered under the policy/certificate? Yes No If Yes, give details below.

Table with 3 columns: Dependent's Name (Last, First, M.I.), Relationship to You, Date of Birth*. Includes a 'Spouse' entry.

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

- 2. Are you or is any family member (whether or not named in this application) an expectant mother or father? Yes No
If yes, coverage cannot be issued if the newborn child would be a covered person from the time of birth, under the terms of the policy/certificate.
3. Within the last 7 years, have you or anyone named above been declined for insurance due to health reasons?
4. Have you or 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?
5. Do you or any person named in Question 1 now have hospital or medical expense insurance that will not terminate prior to the requested effective date?
6. Within the last 5 years, have you or 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, or tested positive for HIV infection?

PLAN: [] Short Term Medical SM Plus [] Short Term Medical SM Value REQUESTED EFFECTIVE DATE: []/[]/[]
DEDUCTIBLE: [] \$ 250 (not available with 7-12 month terms) [] \$ 500 [] \$ 1,000 [] \$ 1,500 [] \$ 2,500
[] \$ 5,000 [] \$ 10,000 (not available with Short Term Medical SM Value)
MONTHS OF COVERAGE: [] 1 [] 2 [] 3 [] 4 [] 5 [] 6 [] 7 [] 8 [] 9 [] 10 [] 11 [] 12

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 at its Lawrenceville or Indianapolis Office 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/certificate which 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 at its Lawrenceville or Indianapolis Office. 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 [] Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child
X [] State where you signed this application
X [] Date you signed and read application
[] Licensed Agent or Broker (Please Print) [] Individual Producer #

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.

To Continue Your Application for Coverage, You Must Become A Member Of FACT

Read and fill out the following FACT Membership Enrollment Form.

FACT MEMBERSHIP ENROLLMENT FORM

I hereby enroll for Full Associate membership in the FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS (FACT). Upon completion of this enrollment form and payment of initial dues (\$3 monthly), I understand that: (a) I will be entitled to FACT's benefits; (b) these benefits may change from time to time; (c) my membership will become effective on the day this enrollment form is dated and signed; (d) I am eligible to apply for association group insurance; and (e) I authorize the release of my name and address listed on the Golden Rule Insurance Company Application for Short Term Medical Insurance to FACT.

X
Member's Signature Date

E-mail Address:

If you wish to apply for association group insurance, please complete the application.

FACT ENFO STM 0908

PAYOR INFORMATION (If other than Proposed Insured)

Payor:
Name E-mail Address

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 nonrefundable application fee.)
For this method of payment, you must make check or money order payable to FACT. (EFT available with online application)

Credit card \$ Amount (Total Single Payment on reverse. Includes \$20 nonrefundable application fee.)
For this method of payment, you must complete the Credit Card Authorization below.

Credit Card Authorization Visa MasterCard

I authorize FACT or 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:

Initial Payment Check or money order EFT (online application only)

\$ Amount (Total Initial Payment on reverse. First month amount (shown) includes a one-time \$20 nonrefundable application fee.)

Ongoing Payments (Choose one)

Direct Bill (\$10 monthly billing fee)

Additional monthly Direct Bill payments will not include the \$20 application fee, however they will include a \$10 monthly billing fee.

Electronic Funds Transfer (EFT) (no billing fee)

Additional monthly EFT payments will not include the \$20 application fee. For this method of payment, you must complete the EFT Authorization below.

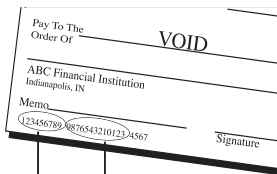
ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION — ONLY IF PAYING BY EFT

I (we) hereby authorize FACT or 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.

Please Return Application by one of the following options:

- Fax **(866)707-9532** Use fax if you are making your first month's premium payment by:

- Credit Card
- EFT (Electronic Funds Transfer)

- Request Secure Email

by sending an email to **insurance@rxmom.com**
Subject :Secure Application we will reply to you securely and you can send your application securely by replying and attaching your application.

Use secure fax if you are making your first month's premium payment by:

- Credit Card
 - EFT (Electronic Funds Transfer)
- Credit Card Payment for 1st month's Premium required

- Mail If paying by check - Send your application including your First Month Premium Check or Money Order Made out to " Golden Rule Insurance" to

RxMom.com Insurance
Golden Rule Processing
7272 Cradlerock Way Ste 100
Columbia MD 21045