

I hereby enroll for Basic \$4 Choice \$20 Elite \$40 membership in the FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS (FACT). Upon completion of this enrollment form and payment of initial dues, I understand that: (a) I will be entitled to FACT's benefits; (b) these benefits may change from time to time; (c) some benefits may have a delayed effective date; (d) my membership will become effective on the day this enrollment form is dated and signed; (e) I am eligible to apply for association group insurance; and (f) I authorize the release of my name, address, date of birth, certificate and phone numbers, application date, membership level, and email address listed on the Golden Rule Insurance Company Application for Insurance to FACT. NOTE: Accident Insurance is included in your FACT membership and you will have an opportunity to name your beneficiary(ies) by mail or on the FACT website.

Member's Signature X _____ Date X _____

FACT ENFO 1110 If you wish to apply for association group health insurance, please complete the application below.

**GOLDEN RULE INSURANCE COMPANY
APPLICATION FOR INSURANCE**

MUST BE COMPLETED BY THE APPLICANT(S)

PLEASE PRINT IN BLACK INK

APPLICANT(S) INFORMATION

1. **REASON FOR APPLICATION:** New Application Add a dependent ID Number _____ Reinstatement Change deductible _____
(for additions, reinstatements, or deductible changes)

2. **PRIMARY APPLICANT'S INFORMATION:**

a. Name (Last, First, M.I.): _____

b. Mailing Address _____
Street (Include Apt.) _____
City _____ State _____ ZIP _____

c. 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 _____

d. Phone Numbers: () () _____
Home Other Best number and times to call Email Address

e. Payor: _____
(If not You): Name _____ Email Address _____
Street _____ City _____ State _____ ZIP _____

f. Your Beneficiary: _____ You will be the beneficiary for your spouse.
Name Relationship Age

g. Your Occupation: _____ h. Marital Status: Married Single

3. **APPLICANTS FOR COVERAGE:** Please list only those persons needing coverage.

Gender	Name (Last, First, M.I.)	Social Security No.	Birth Date	Age	If Full-time Student*	MUST BE ACCURATE	
						Height	Weight
<input type="checkbox"/> Male <input type="checkbox"/> Female	a. Primary (You)						
<input type="checkbox"/> Male <input type="checkbox"/> Female	b. Spouse						
<input type="checkbox"/> Male <input type="checkbox"/> Female	c. Child						
<input type="checkbox"/> Male <input type="checkbox"/> Female	d. Child						
<input type="checkbox"/> Male <input type="checkbox"/> Female	e. Child	NOT REQUIRED					
<input type="checkbox"/> Male <input type="checkbox"/> Female	f. Child						
<input type="checkbox"/> Male <input type="checkbox"/> Female	g. Child						

If you need to list additional dependents, please use lined paper, sign and date it, and check this box.

*A full-time student is one who is enrolled in and attending an accredited college or university on a full-time basis.



4. Do all applicants, other than dependent children, read, write, speak, and understand the English language? Yes No

COVERAGE INFORMATION — Must complete for all new applications, including child only.

5. Requested Effective Date: ___/___/___
6. All plans include a preferred network. Network Name: _____
7. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, indicate who below.) Yes No
a. Primary b. Spouse c. Child d. Child e. Child f. Child g. Child
 Yes Yes Yes Yes Yes Yes Yes
8. **Requested Health Class:** Primary: Preferred I Preferred II Standard I Standard II
 Spouse: Preferred I Preferred II Standard I Standard II
9. **For additions and reinstatements, complete only if changing the deductible for all insureds.**

PRODUCT SELECTION & BILLING (or attach a health insurance quote)

<p><input type="checkbox"/> Copay SelectSM</p> <p><input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$3,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000</p> <p>Coinsurance — Out-of-Pocket Maximum After Deductible <input type="checkbox"/> 0% <input type="checkbox"/> 80/20 — \$3,000 <input type="checkbox"/> 70/30 — \$5,000</p> <hr/> <p><input type="checkbox"/> Plan 100[®] <input type="checkbox"/> Plan 80SM <input type="checkbox"/> Saver 80SM</p> <p><input type="checkbox"/> \$1,000 (<i>Saver 80</i> only) <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000</p> <hr/> <p><input type="checkbox"/> HSA 100[®] <input type="checkbox"/> HSA 70SM</p> <p><input type="checkbox"/> \$1,250 (Single Only) <input type="checkbox"/> \$2,500 (Single and Family) <input type="checkbox"/> \$3,000 (Single Only) <input type="checkbox"/> \$3,500 (Single Only) <input type="checkbox"/> \$5,000 (Single and Family) <input type="checkbox"/> \$6,000 (Family Only) <input type="checkbox"/> \$7,000 (Family Only) <input type="checkbox"/> \$10,000 (Family Only)</p>	<p>FACT Membership Dues (Basic \$4, Choice \$20, Elite \$40): \$ _____</p> <p>Base Premium Amount + _____</p> <p>OPTIONAL BENEFITS — See current brochure for availability</p> <p><input type="checkbox"/> \$25 Office Visit Copay + _____ Optional</p> <p><input type="checkbox"/> 4-Dr. Office Visit Copay - _____ Optional</p> <p><input type="checkbox"/> Prescription Drug — \$200 Deductible + _____ Optional</p> <p><input type="checkbox"/> Prescription Drug — Copay Card + _____ Optional</p> <p><input type="checkbox"/> Prescription Drug — Discount Card Only - _____ Optional</p> <p><input type="checkbox"/> Prescription Drug — Generic Only - _____ Optional</p> <p><input type="checkbox"/> Supplemental Accident: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000 <input type="checkbox"/> \$10,000 + _____ Optional</p> <p><input type="checkbox"/> Term Life: Primary <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 + _____ Optional</p> <p><input type="checkbox"/> Term Life: Spouse <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000 + _____ Optional</p> <p><input type="checkbox"/> Accidental Death: Primary + _____ Optional</p> <p><input type="checkbox"/> Accidental Death: Spouse + _____ Optional</p> <p><input type="checkbox"/> UnitedHealthcare Vision + _____ Optional</p> <p><input type="checkbox"/> Mental Disorders and Substance Abuse + _____ Optional</p> <hr/> <p><input type="checkbox"/> HSA Deposit + _____ \$25 Monthly Min.</p> <hr/> <p>Total Monthly Payment = \$ _____</p> <p>One-Time HSA Set-Up Fee + _____ \$10</p> <p>Initial Monthly Payment (Payable to "FACT") = \$ _____</p> <hr/> <p>If Quarterly, Total Monthly Payment x 3 = \$ _____</p> <p>One-Time HSA Set-Up Fee + _____ \$10</p> <p>Initial Quarterly Payment (Payable to "FACT") = \$ _____</p>
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10. **Initial Payment With Application:** Check EFT Credit Card
Ongoing Payments: **Monthly** EFT (no billing fee) Direct Bill (\$10 monthly billing fee) List Bill (include forms; \$25 monthly admin. fee per list bill group)
Quarterly Direct Bill (\$10 quarterly billing fee)

Premium will be verified and may be adjusted up or down during the underwriting process.

PREVIOUS OR CURRENT HEALTH INSURANCE COVERAGE (Completing this section may make you eligible for an earlier effective date for illnesses.)

11. Within the last 63 days, has any applicant **been covered** by any type of **medical** insurance? Yes No
 If yes, complete chart below. Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced.

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

12. Will the term life benefit replace any existing **life** insurance? Yes No
 Company Name _____ Policy Number _____
13. Has any applicant ever had an application or policy voided, declined, rated, 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: _____
14. Has any applicant previously applied for, or been covered by, Golden Rule or UnitedHealthcare? Yes No
 Name _____ Policy/Certificate Number _____

DRIVING — FOR ALL APPLICANTS

15. 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. Which applicant(s)? a. Primary b. Spouse c. Child d. Child e. Child f. Child g. Child
- b. Does applicant have a valid motorcycle license? Yes Yes Yes Yes Yes Yes Yes
- c. Within the last 24 months, has the applicant had any motor vehicle license suspended or revoked? Yes No
- d. Within the last 24 months, has the applicant, while operating any 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! YOU MUST PROVIDE DETAILS OF EACH YES ANSWER IN THE "MEDICAL HISTORY DETAILS" SECTION.

16. Are you, or is any family member (whether or not named in this application), pregnant or an expectant mother or father, or in the process of surrogate pregnancy, or do you or any family member have an adoption pending? Yes No
17. In the last 5 years, has any applicant filed a claim and/or received benefits from disability insurance or Worker's Compensation? Yes No
18. Has any applicant had or been advised to have: (a) any testing (other than routine testing, such as pap or mammogram); or (b) any treatment, which has not yet been completed? Yes No
19. In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind? Yes No
20. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more? Yes No
21. In the last 5 years, has any applicant used an illegal drug; had any diagnosis or treatment of an alcohol or drug dependency, problem, or abuse; been advised to reduce alcohol intake; or had any alcohol- or drug-related moving violation, arrest, or driver's license suspension? Yes No
22. Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks* per week? Yes No
 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, or 1 oz. of hard liquor).

MEDICAL HISTORY — FOR ALL APPLICANTS (continued)

23. In the last 10 years, has any applicant:
- | | | |
|--|--------------------------|--------------------------|
| | Yes | No |
| a. Had a complicated pregnancy or delivery (including a caesarean section)? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Consulted a health care provider for any condition or symptom(s) for which a diagnosis has not been established? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Had any signs, symptoms, diagnosis, or treatment of Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness, or tested positive for antibodies to the HIV virus? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Had any abnormal physical exam, X-ray, EKG, MRI, CT scan, or any adverse or abnormal laboratory or other test results? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Been confined in a hospital for anything other than childbirth? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Had surgery? | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Had placement, treatment, or maintenance of an internal or external implant or prosthetic device? | <input type="checkbox"/> | <input type="checkbox"/> |

In the last 10 years, has any applicant had testing or additional tests recommended for, or had any signs, symptoms, diagnosis, or treatment of, any disease, disorder, or abnormality of any of the following:

- | | | | | | | |
|--|--------------------------|--------------------------|--|---|--------------------------|--------------------------|
| | Yes | No | | | Yes | No |
| 24. Digestive System | | | | 31. Blood, Gland, Endocrine, or Metabolic | | |
| a. gallbladder, pancreas, or liver? | <input type="checkbox"/> | <input type="checkbox"/> | | a. thyroid, breast, or other glands? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. ulcers? | <input type="checkbox"/> | <input type="checkbox"/> | | b. diabetes or sugar in the blood or urine? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. gastroesophageal reflux disease (acid reflux, GERD)? | <input type="checkbox"/> | <input type="checkbox"/> | | c. anemia? | <input type="checkbox"/> | <input type="checkbox"/> |
| d. rectal bleeding? | <input type="checkbox"/> | <input type="checkbox"/> | | d. immune system disorder (other than AIDS or HIV)? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. other digestive system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> | | e. other blood, endocrine, or metabolic disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 25. Urinary System | | | | 32. Brain and Nervous System | | |
| a. kidney? | <input type="checkbox"/> | <input type="checkbox"/> | | a. migraines or chronic or severe headaches? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. other urinary system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> | | b. seizures or epilepsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| 26. Eyes, Ears, Nose | | | | c. mental, emotional, or behavioral disorder (including anorexia or bulimia)? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. ear or sinus infections (more than two in the past 12 months)? | <input type="checkbox"/> | <input type="checkbox"/> | | d. multiple sclerosis or paralysis? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. other disorder or condition of the eyes, ears, or nose? | <input type="checkbox"/> | <input type="checkbox"/> | | e. other brain or nervous system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 27. Mouth, Throat, or Jaw | <input type="checkbox"/> | <input type="checkbox"/> | | 33. Muscular or Skeletal System | | |
| 28. Skin Disorders | <input type="checkbox"/> | <input type="checkbox"/> | | a. joints, bones, spine, or back? | <input type="checkbox"/> | <input type="checkbox"/> |
| 29. Heart or Circulatory System | | | | b. arthritis or fibromyalgia? | <input type="checkbox"/> | <input type="checkbox"/> |
| a. chest pain? | <input type="checkbox"/> | <input type="checkbox"/> | | c. amputation? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. high or low blood pressure? | <input type="checkbox"/> | <input type="checkbox"/> | | d. other muscular/skeletal system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. elevated cholesterol? | <input type="checkbox"/> | <input type="checkbox"/> | | 34. Respiratory System | | |
| d. stroke? | <input type="checkbox"/> | <input type="checkbox"/> | | a. asthma or allergies? | <input type="checkbox"/> | <input type="checkbox"/> |
| e. shunts, stents, or pacemaker? | <input type="checkbox"/> | <input type="checkbox"/> | | b. sleep apnea? | <input type="checkbox"/> | <input type="checkbox"/> |
| f. other heart or circulatory system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> | | c. other respiratory system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> |
| 30. Male or Female Reproductive System | | | | 35. Cancer, Cyst, or Tumor | | |
| a. infertility or erectile dysfunction? | <input type="checkbox"/> | <input type="checkbox"/> | | a. cancer? | <input type="checkbox"/> | <input type="checkbox"/> |
| b. sexually transmitted disease? | <input type="checkbox"/> | <input type="checkbox"/> | | b. tumor, cyst, polyp, lump, or growth of any kind? | <input type="checkbox"/> | <input type="checkbox"/> |
| c. abnormal mammogram or Pap smear? | <input type="checkbox"/> | <input type="checkbox"/> | | 36. Birth Defects or Congenital Abnormalities | | |
| d. other male or female reproductive system disorder or condition? | <input type="checkbox"/> | <input type="checkbox"/> | | a. Down's syndrome? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | b. cerebral palsy? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | c. other birth defect or congenital abnormality? | <input type="checkbox"/> | <input type="checkbox"/> |
| | | | | | Yes | No |
| 37. In the last 5 years, has any applicant had any signs, symptoms, diagnosis, or treatment for any other disease, disorder, injury, or condition (excluding childbirth) that is not listed on this application? | <input type="checkbox"/> | <input type="checkbox"/> | | | <input type="checkbox"/> | <input type="checkbox"/> |

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.

MEDICAL HISTORY DETAILS — FOR ALL APPLICANTS

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

Question Number: _____ Person: _____ Dates: _____

Symptoms or Conditions: _____

Prescriptions (include dose, how often taken, dates taken): _____

Treatment, Advice Given, Results, and Other Details: _____

Name, Address, Phone of Doctors, Hospitals, etc.: _____

If you need more space to provide complete and accurate information, please use lined paper, sign and date it, and check this box.

SPECIAL INSTRUCTIONS

STATEMENT OF UNDERSTANDING — Review the completed application and read the section below carefully before signing.

I personally completed this application. I represent that the answers and statements on it are true, complete, and correctly recorded.

I understand and agree that:

- (1) This application and the initial payment do not give me immediate coverage.
- (2) I should not terminate existing coverage until I have accepted the Golden Rule coverage.
- (3) Unless Golden Rule agrees to an earlier date, coverage for illness begins on the 15th day after a person becomes insured for injury.
- (4) There will be no benefits for any loss incurred in the first year of coverage due to a preexisting condition (does not apply to applicants under the age of 19).
- (5) **Incorrect or incomplete information on this application may result in voidance of coverage and claim denial.**
- (6) This completed application, and any supplements or amendments, will be a part of any policy/certificate, if issued.
- (7) The broker may only submit the application and initial payment, and may not promise me coverage, modify Golden Rule's underwriting policy or terms of coverage, or change or waive any right or requirement.
- (8) The broker may receive copies of any correspondence about my medical history when correspondence is required.
- (9) **If I continue other coverage existing on the Golden Rule effective date for more than 90 days after that date, the Golden Rule coverage will be void.**
- (10) I must notify Golden Rule of any medical conditions or treatment arising between the date of this application and the effective date of my coverage.
- (11) I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding all listed dependents.
- (12) If Golden Rule rejects this application, under no circumstances will any benefits be payable. Receipt of money, cashing of my check, or charging my credit card by Golden Rule does not constitute approval of my application or create Golden Rule coverage.
- (13) Golden Rule may request additional information, and this may delay the processing of this application. If the health care provider charges a fee for these services, Golden Rule will determine its payment, and I will be responsible for any difference.
- (14) Golden Rule has the right to rely upon the answers and statements in this application, without requesting medical records from any provider listed.

I have received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

X _____
Primary Applicant (You)

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

X _____
Spouse (If to be covered)

____ / ____ / ____
Date

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 12, "Will the term life benefit replace any existing life insurance?" (If the response shown for Question 12 does not reflect your understanding, please check this box and attach an explanation.)

X _____
Signature of Licensed Broker

X _____
Print Full Name

Broker Number

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.

reporting agency, or MIB, Inc., formerly known as Medical Information Bureau (MIB) having information about my occupation(s), avocations, driving history, criminal history, or prior insurance coverage for my family or me is authorized to give it to Golden Rule's Insurance Administration and Claims Departments.

I certify that:

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.

- (a) I am not employed by an employer with 2-50 employees; or
- (b) I am employed by an employer with 2-50 employees; however, no portion of the premium is paid, either directly or indirectly, by my employer.

I (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

If you cannot certify to either (a) or (b) above, you are not eligible to apply for this plan.

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.

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.

953B-799

ANI-0311

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 employer, insurance company, government agency, consumer-

I have read the above: Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.

Signed X ____/____/____
Date

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, consumer-reporting agency, MIB, Inc., formerly known as 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 (we) have received Golden Rule's Notice of Information Practices. This authorization shall remain valid for 30 months from the date below.

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.

I (we) understand the following:

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.

- 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 ____/____/____
Date

X _____
Signature of Primary Applicant (You)

X _____
Signature of Parent/Guardian (If you are a minor)

X _____
Signature of Spouse (If to be covered)

HEALTH SAVINGS ACCOUNT (HSA) APPLICATION (only if opening an HSA with OptumHealth Bank)

By signing to the right, I acknowledge that:

- I wish to establish a health savings account (HSA) with OptumHealth Bank as custodian.
- I understand the eligibility requirements for deposits made to my HSA and state that I qualify to make deposits to this account. I have reviewed this application and understand and agree that my HSA will be opened under and governed by OptumHealth Bank's Custodial and Deposit Agreement and that the terms and conditions therein will be binding on me. This document will be sent to me when my account is opened, along with OptumHealth Bank's Privacy Policy and Schedule of Fees.
- I authorize OptumHealth Bank to provide information about my HSA, including my account number, to Golden Rule, and those acting on behalf of Golden Rule or OptumHealth Bank (if applicable), in connection with the establishment and