

Please read the Short Term Medical<sup>SM</sup> brochure and this separate, state-specific Application and Payment Information thoroughly and carefully.

## Instructions for Applying for Coverage

To Calculate Payment(s), follow the numbered steps below and to the right.

- 1) Monthly Base Premium Rate chart.** The rates are separated by Deductible: Male, Female, and Per Dependent Child. Determine which Deductible you are applying for, and find the appropriate rate for your age (as of the requested effective date) and gender. Similarly, find the rates for your spouse and children. If parents are not applying, see **“\*Child(ren) rates without Parents”** under your state’s Base Rates chart. Enter the amounts in the spaces shown.

**Subtotal your Rates.**

- 2) Multiple Person Discount.** If you are the only person applying for coverage, multiply the Subtotal by 1.00. If more than one person is applying for coverage, multiply the Subtotal by 0.90. *(This option will reduce your premium payment.)*

**Subtotal.**

- 3) Trend Factor.** Using your effective date, determine the trend factor from this chart. Multiply the Subtotal by this number.

**Subtotal.**

March through September 2006 . . . . .	<b>1.00</b>
October 2006 through March 2007 . . . . .	<b>1.04</b>
April through September 2007 . . . . .	<b>1.08</b>
October 2007 through March 2008 . . . . .	<b>1.12</b>

- 4) ZIP Code Area Factor.** Using the first three digits of your ZIP Code, determine your Area Factor from the state-specific ZIP Code Area Factors chart. Multiply the Subtotal by this number.

**Subtotal.** This is your Total Health Premium.

Step 5 applies to **Monthly** EFT Payment option only.

- 5) If Monthly EFT,** multiply by the Monthly Processing Fee Factor of 1.10. *(Applicable to **Monthly EFT Payment option only.**)*

**Subtotal.**

- 6) Add FACT membership dues.** You must become a member of FACT to apply for *Short Term Medical* coverage, and pay the \$3 **monthly** membership fee. Please remember to fill out the Membership Enrollment Form with your application.

**Subtotal.**

Step 7 applies to **Single** Payment option only. *(One single payment.)*

- 7) If Single Payment option,** **determine the Number of Months of coverage.** Multiply by the Number of Months the insurance is needed. *(Applicable to **Single Payment option only.**)*

**Subtotal.**

- 8) Nonrefundable Application Fee.** *(Included only in Initial Payment if paying monthly.)*

**Total.**

\*Additional EFT Payments will not include the \$20 Application Fee.

**This is your Total Payment Payable to FACT.**

**If Monthly EFT Payment option:** Complete the **Monthly Payment: Electronic Funds Transfer (EFT) Authorization** section on other side. Be sure to include a voided blank check or a blank deposit slip for your checking account with this authorization.

**If Single Payment option:** Make check or money order payable to FACT, or complete the **Single Payment: Credit Card** section on the application if you are paying by credit card.

# Texas

## Application and Payment Information

### Calculate Payment(s)

1) Monthly Base Premium Rate <i>(see chart on right)</i>	
a) Your Rate .....	_____
b) Spouse Rate .....	+ _____
c) Child Rate <i>(no. of children _____ x \$ _____)</i> .....	+ _____
<b>Subtotal</b> .....	= _____
2) Multiple Person Discount .....	x _____
<i>(1 person = 1.00) (2 or more = .90)</i>	
<b>Subtotal</b> .....	= _____
3) Trend Factor <i>(see chart on left)</i> .....	x _____
<b>Subtotal</b> .....	= _____
4) ZIP Code Area Factor <i>(see chart on right)</i> .....	x _____
<b>Subtotal</b> .....	= _____

**Two Payment Options:** *You can choose*

**Monthly Payments or One Single Payment**

**Monthly Payments**

**One Single Payment**

	Monthly Payments	One Single Payment
5) Monthly Processing Fee <i>(if paying monthly)</i> .....	x <b>1.10</b>	N/A
<b>Subtotal</b> .....	= _____	N/A
6) FACT Dues <i>(per month)</i> .....	+ <b>\$ 3.00</b>	+ <b>\$ 3.00</b>
<b>Subtotal</b> .....	= _____	= _____
7) Number of Months <i>(if applicable) (1 to 6)</i> .....	N/A	x _____
<b>Subtotal</b> .....	= _____	= _____
8) Application Fee <i>(one-time fee)</i> .....	+ <b>\$ 20.00*</b>	+ <b>\$ 20.00</b>
<b>Total Payment Payable to FACT</b> .....	= <b>\$ _____</b>	= <b>\$ _____</b>
	<b>Total Initial Payment</b>	<b>Total Single Payment</b>

## 1) Texas Monthly Base Premium Rates

AGE	\$250 DEDUCTIBLE		\$500 DEDUCTIBLE		\$1,000 DEDUCTIBLE		\$1,500 DEDUCTIBLE		\$2,500 DEDUCTIBLE	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
To 24	64	61	44	42	31	28	27	25	23	21
25-29	66	69	45	48	32	33	28	29	24	25
30-34	69	79	49	55	34	38	30	34	26	29
35-39	74	90	53	63	37	43	33	38	28	33
40-44	90	104	65	73	47	50	42	45	36	38
45-49	109	119	78	84	59	61	52	54	44	46
50-54	133	135	97	98	74	74	66	66	56	56
55-59	177	159	129	116	101	89	89	79	76	68
60-64	219	182	159	131	123	102	110	91	93	77
Per Dependent Child*	33	33	23	23	15	15	13	13	11	11

**\*Child(ren) rates without Parents.** If you are calculating rates for one child without parents, use the Male or Female "To 24" rate for the child. For two or more children without parents, use the Male or Female "To 24" rate for the youngest child and add the "Per Dependent Child" rate for each additional child.

## 4) Texas ZIP Code Area Factors

ZIP CODE	AREA FACTOR
750-753, 757-761	1.425
754-756, 762-764, 766-777,	
785, 788, 790-799, 885	1.550
765, 778-784	1.250
786, 787, 789	1.050

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

No application will be accepted if received by Golden Rule at its Home Office or Indianapolis Office more than 15 days after the date signed.

PROPOSED INSURED

First Middle Initial Last Social Security Number Birth Date Age Sex (Male/Female)

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 7 columns: Dependent's First Name, Relationship to You, Social Security Number, Date of Birth, Dependent's First Name, Relationship to You, Date of Birth. Includes entries for Spouse and N/A.

\*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... an expectant mother or father?
3. 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...
7. Within the last 5 years, have you or anyone listed on the application been diagnosed with or treated for immune system disorders...

DEDUCTIBLE: \$ 250 \$ 500 \$ 1,000 \$ 1,500 \$ 2,500 REQUESTED EFFECTIVE DATE: / /

MONTHS OF COVERAGE: 1 MO. 2 MO. 3 MO. 4 MO. 5 MO. 6 MO.

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 Home 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.

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

ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

Important Note: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service.

# 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 \_\_\_\_\_ X \_\_\_\_\_  
Member's Signature Date

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

FACT ENFO STM 0105

## Payment Options: *Must choose one*

**Single Payment: Check or money order \$ Amt.** \_\_\_\_\_ (Total Single Payment on reverse)  
For this method of payment, you must make check or money order payable to FACT. (EFT also available with on-line application)

*OR*

**Single Payment: Credit card \$ Amt.** \_\_\_\_\_ (Total Single Payment on reverse)  
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.

Account No. \_\_\_\_\_ Expiration Date \_\_\_\_/\_\_\_\_/\_\_\_\_ Security Code \_\_\_\_  
(Last 3 digits in signature line)

\_\_\_\_\_  
Name on Credit Card X \_\_\_\_\_ Signature of Authorized User Phone No. \_\_\_\_\_

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

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

*OR*

**Monthly Payment: Electronic Funds Transfer (EFT) \$ Amt.** \_\_\_\_\_ (Total Initial Payment on reverse)  
The 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

I hereby authorize FACT or Golden Rule Insurance Company 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 of its termination.

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

Financial Institution

Name \_\_\_\_\_ Address \_\_\_\_\_

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

Account Holder (Printed Name)

Name \_\_\_\_\_ Address \_\_\_\_\_

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

Draft On \_\_\_\_\_ of each month X \_\_\_\_\_ Phone No. \_\_\_\_\_  
Day Signature of Account Holder -- As shown on the account to which this authorization is applicable

\_\_\_\_\_  
/ /  
Date

**IMPORTANT: BE SURE TO INCLUDE A VOIDED BLANK CHECK OR A BLANK DEPOSIT SLIP FOR YOUR CHECKING ACCOUNT WITH THIS AUTHORIZATION.**