

**FACT Membership Enrollment Form**

**Florida**

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.





**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. Has any applicant: (a) tested positive for exposure to the HIV infection; (b) been diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) caused by HIV infection; or (c) been diagnosed as having any other sickness or condition derived from an HIV infection? ..... | <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                       |
| <b>24. Digestive System</b>  |                          |                          | <b>31. Blood, Gland, Endocrine, or Metabolic</b>                                    |                          |                          |
| 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"/> |
| <b>25. Urinary System</b>  |                          |                          | <b>32. Brain and Nervous System</b>   |                          |                          |
| 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"/> |
| <b>26. Eyes, Ears, Nose</b>  |                          |                          | 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"/> |
| <b>27. Mouth, Throat, or Jaw</b> .....                                   | <input type="checkbox"/> | <input type="checkbox"/> | <b>33. Muscular or Skeletal System</b>  |                          |                          |
| <b>28. Skin Disorders</b> .....  | <input type="checkbox"/> | <input type="checkbox"/> | a. joints, bones, spine, or back? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| <b>29. Heart or Circulatory System</b>                                   |                          |                          | 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"/> | <b>34. Respiratory System</b>   |                          |                          |
| 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"/> |
| <b>30. Male or Female Reproductive System</b>                            |                          |                          | <b>35. Cancer, Cyst, or Tumor</b>   |                          |                          |
| 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"/> | <b>36. Birth Defects or Congenital Abnormalities</b>                                |                          |                          |
| 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"/> |

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? .....
- |  |                          |                          |
|--|--------------------------|--------------------------|
|  | Yes                      | No                       |
|  | <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**

This policy is primarily governed by the laws of Illinois. As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida-approved policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for another individual health policy. For information concerning individual health coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

**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

\_\_\_\_\_  
Broker Number

\_\_\_\_\_  
FL Agent Number

X \_\_\_\_\_  
Countersigned by Licensed Resident Agent

X \_\_\_\_\_  
Print Full Name

\_\_\_\_\_  
Broker Email Address

**IMPORTANT INFORMATION**

**Before You Submit Your Application:**

- If you were previously insured by UnitedHealthcare or any of its companies, you still must complete this application fully and accurately.
- Read the applicable product brochure(s).
- Altered applications will not be accepted.
- Brokers must be licensed with Golden Rule in the state where an application is signed and the state where the primary applicant resides.
- **Coverage is not available if:**
  - Any family member, whether or not named in this application, is currently pregnant; or
  - The applicant has not resided in the U.S. for at least 12 consecutive months.

**Important Information:**

- Any person who knowingly presents false, incomplete, or misleading information in an application for insurance may be committing insurance fraud.
- You must disclose your full health history and the full health history of all applicants listed on the application. Even if your application is approved, any omissions or false statements may result in future claims being denied and/or termination or rescission of coverage.
- Include all requested details and explanations. If you need to include additional information, attach an extra sheet of paper. Include your signature and date on the extra sheet.
- Do not cancel any existing coverage you might have until you are notified that your application has been approved.

**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) 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.

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

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

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-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.

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.

ANI-0311

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

Signed X     /    /      
Date

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

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

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 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     /    /      
Date

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

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

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

36228-0311

**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 maintenance of my HSA.
- I acknowledge that Golden Rule and all others acting on behalf of Golden Rule, may provide information on my behalf to establish and maintain my HSA and authorize Golden Rule and its designee to take such action deemed necessary and appropriate by Golden Rule to administer my HSA, including but not limited to, making deposits and correcting errors where necessary.
- I understand my monthly account statements will be made available to me electronically. I agree to notify OptumHealth Bank if I wish to have statements mailed to my home address.
- I have requested a MasterCard Prepaid Debit Card and if I have filled out the information to request an Authorized User debit card, I hereby request OptumHealth 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 authorize OptumHealth Bank to share information about my HSA with the Authorized User named and to allow any account transactions made by such Authorized User.
- I certify that the information provided in this application is true and complete.

X \_\_\_\_\_  
Signature of Primary Applicant

Primary Applicant's Social Security Number \_\_\_\_\_

Applicant's Spouse Social Security Number \_\_\_\_\_

**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.

**REQUEST FOR AN AUTHORIZED USER DEBIT CARD (OPTIONAL)**

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

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

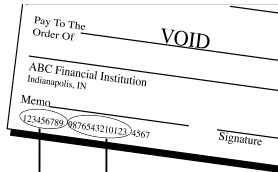
Authorized User's \_\_\_\_\_  
Date of Birth

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

155X-1108

**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

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.

X \_\_\_\_\_  
Authorized Account Signature

Email Address \_\_\_\_\_

**INITIAL PAYMENT CREDIT CARD AUTHORIZATION**

I authorize FACT or Golden Rule to bill my MasterCard/Visa 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 Exp. Date: \_\_\_\_\_  
Month Year

Billing ZIP Code: \_\_\_\_\_

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

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

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

# FLORIDA CERTIFICATION

Review the statements and sign where appropriate.

**Decide whether or not all of the statements 1-6 apply to you.**

1. I do not have any other health insurance coverage (or it will be involuntarily terminated soon).
2. I have been insured by *creditable coverage*<sup>1</sup> (as defined below) for the last 18 months or more with no lapse in coverage of more than 63 days.
3. My most recent coverage was under a *group health plan*<sup>2</sup> (as defined below), a governmental plan, or a church plan; or under an individual plan that terminated due to: the insurer's insolvency; the insurer's discontinuance of all its individual coverage in Florida; or the fact that I no longer live in a Florida service area of my prior insurer's network plan.
4. My most recent coverage was not terminated due to nonpayment of premiums, fraud, or intentional misrepresentations.
5. I am not eligible for any coverage under a conversion plan, a *group health plan*<sup>2</sup> (as defined below), Medicare, or Medicaid.
6. I accepted and exhausted any group continuation of coverage (including COBRA) that was offered to me.

**Carefully review the statements above and sign under A. or B.**

**A.** One or more of the six statements above **do not** apply to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

**OR**

**B.** I represent that all six of the statements above **do** apply to me.

Signature \_\_\_\_\_ Date \_\_\_\_\_

<sup>1</sup>*Creditable coverage* includes group or individual health insurance coverage, Medicare, Medicaid, Armed Forces coverage, Indian or tribal coverage, state risk pool coverage, public health coverage, and Peace Corps Act coverage. A plan is NOT *creditable coverage* if it: a) provides coverage only for accidents, disability, or liability; b) is credit-only insurance; or c) is secondary to other insurance.

<sup>2</sup>Generally, a *group health plan* is any coverage existing in connection with employment. Included are: employer-sponsored plans (so long as at least one employee participates); coverage of an employee under an individual policy of insurance that is part of a plan, fund, or program established or maintained by an employer that provides medical care to employees or their dependents; coverage of a business owner so long as at least one employee other than the business owner and the business owner's spouse also participates in the plan; and coverage of partners in a plan maintained by the partnership.