

# North Atlanta Insurance Group

## 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 North Atlanta Insurance Group for review along with the completed application. If you do not have access to a fax machine, send the completed application to North Atlanta Insurance Group 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 payment check made payable to:

- "FACT" for all states except CT, DE, GA, KS, LA, NM, and WY
- "Golden Rule" for CT, DE, GA, KS, LA, NM, and WY only

Mail completed applications and check to:

**North Atlanta Insurance Group**

**Attn: New Enrollment**

**1166 Forest Crest Court**

**Dacula, GA 30019**

North Atlanta Insurance Group 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 770-855-7971 or e-mail us at [naig@bellsouth.net](mailto:naig@bellsouth.net).

Norvax form #IN-1

# North Atlanta Insurance Group

## 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:**

**North Atlanta Insurance Group**

**FAX#**

Dear North Atlanta Insurance Group,

Please accept my completed 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 North Atlanta Insurance Group at 770-855-7971 to verify receipt of my  
application.

**\*\*I understand that North Atlanta Insurance Group 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 North Atlanta Insurance  
Group. I will mail the original signed application to :

**North Atlanta Insurance Group**

**Attn: New Enrollment**

**1166 Forest Crest Court**

**Dacula, GA 30019**

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

Norvax form #CS-1

**GOLDEN RULE INSURANCE COMPANY  
APPLICATION FOR INSURANCE**

To be filled out personally by the applicant(s)

PLEASE PRINT IN BLACK INK

Do not separate application pages

**APPLICANT(S) INFORMATION (Only list persons applying for coverage)**

Name (Last, First, M.I.)	Marital Status	Social Security Number	Birth Date	Age	Sex	Height	Weight
1. Primary (You)	<input type="checkbox"/> M <input type="checkbox"/> S						
2. Spouse							
3. Dependent Children			Birth Date	Age	Sex	Height	Weight
a. Name (Last, First, M.I.)							
b.							
c.							
d.							
e.							

4. Primary Applicant's Address (P.O. Boxes are not accepted.)

Street (Include Apt.) \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

5. Phone Numbers: ( ) ( ) \_\_\_\_\_

Home Other Best number and times to call E-mail Address \_\_\_\_\_

6. Payor (If not You): Name \_\_\_\_\_ Street \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

7. Your Beneficiary: \_\_\_\_\_ Name \_\_\_\_\_ Relationship \_\_\_\_\_ Age \_\_\_\_\_ You will be the beneficiary for your spouse.

8. Your Occupation: \_\_\_\_\_ Date Hired: \_\_\_\_\_ 9. Total Annual Household Income:  \$15,000 or less  \$35,001 to \$50,000  \$75,001 to \$99,999

Prior Employment (If within 2 years): \_\_\_\_\_ Household Income:  \$15,001 to \$35,000  \$50,001 to \$75,000  \$100,000 or more

10. Primary Applicant's Mother's Maiden Name: \_\_\_\_\_ Spouse's Mother's Maiden Name: \_\_\_\_\_

(Last Name Only) (Last Name Only)

Oct 30 2007 09:57:01 am



**COVERAGE INFORMATION**

11. Requested Effective Date: \_\_\_/\_\_\_/\_\_\_ Requested Health Class: Primary:  Preferred  Standard  Tobacco (if question 32 is yes)  
 Plan includes Preferred Network; if not wanted, check here  Spouse:  Preferred  Standard  Tobacco (if question 32 is yes)  
 Network Name: \_\_\_\_\_ Special Instructions: \_\_\_\_\_

<b>Copay Plans</b>	<input type="checkbox"/> Copay Select <sup>SM</sup>	<input type="checkbox"/> \$ 500 <input type="checkbox"/> \$1,000 <input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500	<b>HSA Plans</b>	Single 2007/2008	Family 2007/2008	<b>High Deductible</b>	<input type="checkbox"/> Plan 100 <sup>®</sup>	<input type="checkbox"/> \$ 500 (Saver 80 only)
	<input type="checkbox"/> Copay Saver <sup>SM</sup>	<input type="checkbox"/> \$2,500		<input type="checkbox"/> HSA 100 <sup>®</sup>	<input type="checkbox"/> \$1,100/\$1,100 <input type="checkbox"/> \$1,850/\$1,900 <input type="checkbox"/> \$2,850/\$2,900 <input type="checkbox"/> \$3,500/\$3,500 <input type="checkbox"/> \$5,000/\$5,000		<input type="checkbox"/> \$2,200/\$2,200 <input type="checkbox"/> \$3,800/\$3,850 <input type="checkbox"/> \$5,650/\$5,800 <input type="checkbox"/> \$7,500/\$7,500 <input type="checkbox"/> \$10,000/\$10,000	<input type="checkbox"/> Plan 80 <sup>SM</sup>
<b>Optional</b>	<input type="checkbox"/> Preventive Care (Not with Copay Select) <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 Maximum Maternity <input type="checkbox"/> Supplemental Accident <input type="checkbox"/> Mental Disorder Benefit (Not with Copay Saver)			<input type="checkbox"/> Preventive Care <input type="checkbox"/> Hospital Indemnity Rider (Not Available with \$1,100 or \$2,200 deductible) <input type="checkbox"/> Mental Disorder Benefit (Not with HSA Saver)		<b>Optional</b>	<input type="checkbox"/> Preventive Care <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$4,000 Maximum Maternity <input type="checkbox"/> Supplemental Accident <input type="checkbox"/> Prescription Drug Card (Not with Saver 80) <input type="checkbox"/> Mental Disorder Benefit (Not with Saver 80)	

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

12. Initial Payment With Application:  
 Check  EFT  Credit Card  
 Ongoing Payments:  
 Monthly (EFT)  Quarterly Direct Bill  List Bill (include forms)

**Initial Payment Credit Card Authorization**

I authorize 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

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

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

Card Number

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

Base Premium Amount + \_\_\_\_\_  
 Preventive Care + \_\_\_\_\_ Optional  
 Maternity Benefit + \_\_\_\_\_ Optional  
 Supplemental Accident + \_\_\_\_\_ Optional  
 Prescription Drug Card + \_\_\_\_\_ Optional  
 Mental Disorder Benefit + \_\_\_\_\_ 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 "Golden Rule."

**If Quarterly** → **X3= \$ \_\_\_\_\_** **Total Quarterly Payment**  
 + \_\_\_\_\_ One-Time HSA Set-Up Fee  
 + \_\_\_\_\_ One-Time HSA Indemnity Rider  
**= \$ \_\_\_\_\_** **Initial Payment** ←

**OTHER COVERAGE**

13. Within the last 62 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 # \_\_\_\_\_

**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)? \_\_\_\_\_
- 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"/> | 25. <b>In the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:</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. heart or circulatory system? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. Do you have an adoption pending? .....   | <input type="checkbox"/> | <input type="checkbox"/> | b. nervous system? .....  | <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. digestive system? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. <b>Within the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:</b> |                          |                          | d. muscular or skeletal system? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| a. gallbladder? .....  | <input type="checkbox"/> | <input type="checkbox"/> | e. respiratory system? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. pancreas or liver? .....  | <input type="checkbox"/> | <input type="checkbox"/> | f. male or female reproductive system, including infertility? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| c. joints or spine? .....  | <input type="checkbox"/> | <input type="checkbox"/> | g. urinary system? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| d. kidney? .....   | <input type="checkbox"/> | <input type="checkbox"/> | h. thyroid, breast, or other glands? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. eyes, ears, or nose? .....  | <input type="checkbox"/> | <input type="checkbox"/> | 26. In the last 10 years, has any applicant had any signs, symptoms, diagnosis, or treatment of any Acquired Immune Deficiency Syndrome (AIDS)? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. mouth, throat, or jaw? .....  | <input type="checkbox"/> | <input type="checkbox"/> | 27. In the last 10 years, has any applicant tested positive for antibodies to the HIV virus? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 23. <b>In the last 10 years, has any applicant had any known indication, signs, symptoms, diagnosis, or treatment of:</b>                                    |                          |                          | 28. In the last 10 years, has any applicant had any known 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"/> |
| a. high blood pressure? .....  | <input type="checkbox"/> | <input type="checkbox"/> | 29. 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"/> |
| b. chest pain? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 30. 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"/> |
| c. headaches? .....  | <input type="checkbox"/> | <input type="checkbox"/> | 31. 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"/> |
| d. paralysis? .....  | <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).   |                          |                          |
| e. arthritis? .....  | <input type="checkbox"/> | <input type="checkbox"/> | 32. 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"/> |
| f. convulsions or epilepsy? .....  | <input type="checkbox"/> | <input type="checkbox"/> | 33. 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.                          |                          |                          |
| g. elevated cholesterol? .....   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| h. sexually transmitted disease? .....   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 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. tumor, cyst, polyp, lump, or growth of any kind? .....  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| m. mental, emotional, or behavioral disorder? .....  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| 24. <b>In the last 10 years, has any applicant:</b>  |                          |                          |   |                          |                          |
| a. had a complicated pregnancy or delivery? .....  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| b. been hospital confined, had surgery, or discussed surgery? .....  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |



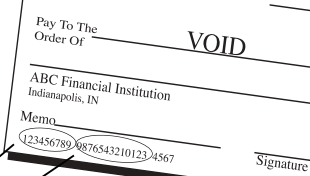
**ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION -- ONLY IF PAYING BY EFT**

I (we) hereby authorize 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 of its termination from me.

Nine-digit Check Routing No. \_\_\_\_\_

Checking 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.

Account Holder's Signature X \_\_\_\_\_

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

**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.

I understand that my premium cannot be paid with an employer check unless I am certifying under (a) above, or my employer has set up a list bill account with Golden Rule.

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

074C-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 the 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.

**I have read the Monthly P.A.C. Authorization and the 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 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 Conditional Receipt or Conditions Prior to Coverage.

X \_\_\_\_\_  
Signature of Licensed Broker

X Cheri Forand \_\_\_\_\_  
Print Full Name

6907952

Broker Number

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

By signing below, I acknowledge that:

- 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 authorize Exante to share information about my HSA with the authorized user named and to allow withdrawals by check, debit card, or other means to be 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 \_\_\_\_\_

**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.

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

**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-0806

**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 "Golden Rule."
- EFT authorization (if paying via EFT).

**Mail to:** Golden Rule Insurance Company  
HEALTH APPLICATION  
PO Box 68994  
Indianapolis, Indiana 46268-0994