Please read the Short Term Medical[SM] 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 Rates 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.
   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.

Effective date	Trend factor
April through September 2011	**1.40**
October 2011 through March 2012	**1.44**
April through September 2012	**1.48**

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.

Step 6 applies to **Single** Payment option only. *(One single payment.)*

6) 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.

7) **Application Fee.**
   Total.

   Additional EFT Payments will not include the $20 Application Fee.
   This fee is only required with the initial payment.

This is your Total Payment Payable to Golden Rule.

If Monthly EFT Payment option: Complete the **Monthly Payment: Electronic Funds Transfer (EFT) Authorization** section on other side.

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

Georgia

Payment Information Worksheet

Calculate Payment(s)

1) Monthly Base Premium Rate *(see chart on right)*

a) Your Rate		____________
b) Spouse Rate	+	____________
c) Child Rate *(no. of children ____ x $____)*	+	____________
Subtotal	=	____________
2) Multiple Person Discount *(1 person = 1.00) (2 or more = .90)*	x	____________
Subtotal	=	____________
3) Trend Factor *(see chart on left)*	x	____________
Subtotal	=	____________
4) ZIP Code Area Factor *(see chart on right)*	x	____________
Subtotal	=	____________

Two Payment Options: *You can choose* **Monthly Payments** *or* **One Single Payment**

	Monthly Payments	One Single Payment
5) Monthly Factor *(if paying monthly)*	x **1.10**	N/A
Subtotal	= ____________	N/A
6) Number of Months *(if applicable) (1 to 6)*	N/A	x ____________
Subtotal	= ____________	= ____________
7) Application Fee *(one-time fee)*	+ **$ 20.00**	+ **$ 20.00**
Total Payment Payable to Golden Rule	= $____________	= $____________
	Total Initial Payment	**Total Single Payment**

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1) Georgia Monthly Base Premium Rates

PRIMARY* & SPOUSE AGE	$500 DEDUCTIBLE		$1,000 DEDUCTIBLE		$1,500 DEDUCTIBLE		$2,500 DEDUCTIBLE	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
13-24	47	45	33	30	29	26	25	22
25-29	48	51	34	35	31	31	26	27
30-34	53	59	37	41	32	37	28	31
35-39	57	67	39	46	35	41	30	35
40-44	69	78	51	54	45	48	38	41
45-49	84	90	63	66	56	58	47	50
50-54	103	105	79	79	70	70	60	60
55-59	139	124	108	96	96	85	81	72
60-64	171	141	132	109	117	97	100	83
Per Dependent Child	24	24	16	16	14	14	12	12

*Primary must be age 19 or older

4) Georgia ZIP Code Area Factors

ZIP CODE	AREA FACTOR
300-304, 306, 310, 311, 398, 399	1.250
305, 307-309, 312-314, 316, 318, 319	1.400
315, 317	1.600

Please Print in Blue Ink.

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

PROPOSED INSURED ______ First ______ Middle Initial ______ Last ______ __/__/__ Birth Date* ______ Age ☐ Male ☐ Female Sex

RESIDENT ADDRESS
P.O. Boxes are not accepted.

______ Street ______ City ______ State ______ ZIP ______ Telephone No.

1. List below any dependents to be covered under the policy.

Dependent's Name (Last, First, M.I.)	Relationship to You	Date of Birth*
	Spouse	/ /
		/ /
		/ /
		/ /
		/ /
		/ /

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

	Yes	No
2. Are you or is any family member (whether or not named in this application) an expectant mother or father? **If yes, coverage cannot be issued.**	☐	☐
3. Have you or has anyone named above been declined for insurance due to health reasons? If yes, state the name of each person: ______ (The person(s) named will not be covered under the policy.)	☐	☐
4. Have you or has 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? If yes, state the name of each person: ______ (The person(s) named will not be covered under the policy.)	☐	☐
5. Do you or does any person named in Question 1 now have hospital or medical expense insurance that **will not** terminate prior to the requested effective date? If yes, state the name of each person: ______ (The person(s) named will not be covered under the policy.)	☐	☐
6. Within the last 5 years, have you or has anyone listed on the application received medical or surgical consultation, advice, or treatment, including medication, for **any of the following:** liver disorders, kidney disorders, emphysema, diabetes, cancer, heart or circulatory system disorders (including high blood pressure), alcohol or drug abuse or immune system disorders, including HIV infection, or tested positive for HIV infection? If yes, state the name of each person: ______ (The person(s) named will not be covered under the policy.)	☐	☐

DEDUCTIBLE: ☐ $ 500 ☐ $1,000 ☐ $1,500 ☐ $2,500

REQUESTED EFFECTIVE DATE: ____/____/____
(See Statement of Understanding section below.)

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 with this application; (b) no benefits will be paid for a health condition that existed within the last 5 years prior to the date insurance takes effect; and (c) if coverage is issued, the coverage will not be a continuation of any prior coverage. Incorrect or incomplete information on this application may result in voidance of coverage and claim denial. The information provided in this application, and any supplement or amendments to it, will be made a part of any policy that may be issued. I understand that for an application sent by any electronic means, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after receipt by Golden Rule. I understand that for a mailed application, insurance, if approved, will be effective the later of: (i) the requested effective date; or (ii) the day after the **postmark date** affixed by the U.S. Postal Service. If mailed and not postmarked by the U.S. Postal Service or if the postmark is not legible, the effective date will be the later of: (i) the requested effective date; or (ii) the date received by Golden Rule. I understand that the broker is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

X ______ Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child

X ______ State where you signed this application

X ______ Date you signed and read application

Steven McClelland — Licensed Agent or Broker (Please Print.)

750320 — Individual Producer #

No application will be accepted if received by Golden Rule more than 15 days after the date signed.

ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

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

PAYOR INFORMATION (If other than Proposed Insured)

Payor: ______________________________

Name | Email Address

Street | City | State | ZIP

PAYMENT OPTIONS: SINGLE OR MONTHLY

☐ **Single Payment** (one single payment for all months chosen/lump sum):

☐ **Check or money order $ Amount** __________ (Total Single Payment on reverse. Includes $20 application fee.)
For this method of payment, you must make check or money order payable to Golden Rule. (EFT available with online application)

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

Credit Card Authorization ☐ Visa ☐ MasterCard

I authorize Golden Rule Insurance Company to bill my Visa/MasterCard account for the total payment.

Account No. | Expiration Date ____/____/____ | Billing ZIP Code | X Signature of Authorized User

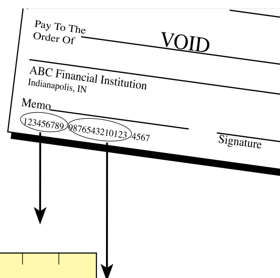
NOTE: Some card issuers/financial institutions charge cash advance fees on insurance payments.

OR

☐ **Monthly Payment: Electronic Funds Transfer (EFT)** (no billing fee): **$ Amount** __________ (Total Initial Payment on reverse. First month 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 — 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 financial institution to debit the same to such account.
I agree this authorization will remain in effect until you actually receive written notification of its termination from me.



Type of Account: ☐ Checking ☐ Savings

Nine-digit Routing No.

Account No.

Financial Institution's Name ______________________________

Address ______________________________

City, State, ZIP ______________________________

Draft On ______________ Day ____/____/____ Date Signed

X ______________________________
Authorized Account Signature

Email Address ______________________________

In Tennessee and Texas, drafts may only be scheduled on 1) the premium due date; or 2) up to 10 days after the due date.