PLEASE NOTE: THIS PRODUCT PROVIDES LIMITED BENEFITS. THIS IS NOT MAJOR MEDICAL OR COMPREHENSIVE HEALTH INSURANCE, AND DOES NOT PROVIDE THE MANDATED COVERAGE NECESSARY TO AVOID PENALTY UNDER THE AFFORDABLE CARE ACT.

GOLDEN RULE INSURANCE COMPANY

SECTION 1 Application for Term Life with Critical Illness

Applicant(s) Information - Must Be Completed by the Applicant(s)

Please Print In Black Ink

Gender	Name (Last, First, M.I.)	Birth Date	Age	MUST BE ACCURATE Height	Weight
☐ Male ☐ Female	Primary (You)				
☐ Male ☐ Female	Spouse				

Mailing Address

Street (Include Apt.)

City State ZIP

Phone Numbers ( ) Home ( ) Work (optional) ( ) Cell (optional) Email Address

A physical address is required if different than your mailing address. PO Boxes are not accepted as a physical address.

Physical Address

Street (Include Apt.)

City State ZIP

Payor (If not You) Name Email Address

Street City State ZIP

Your Beneficiary: Name Relationship Age

Your Occupation: Requested Effective Date: ___/___/___

SECTION 2

Plan Choices

Term Life SafeGuard

☐ Term Life *(choose one)* — ☐ $25,000 ☐ $30,000 ☐ $50,000 ☐ $75,000 ☐ $100,000 ☐ $150,000 ☐ $200,000 $ _____ Premium

Benefit Term *(choose one)* — ☐ 10 Year ☐ 20 Year

☐ Critical Illness Benefit *(optional – choose one)*
- ☐ $15,000 (only available with $30,000 Term Life)
- ☐ $25,000 (only available with $25,000 or $50,000 Term Life)
- ☐ $50,000 (only available with $50,000 or $100,000 Term Life)
- ☐ $75,000 (only available with $75,000 or $150,000 Term Life)
- ☐ $100,000 (only available with $100,000 or $200,000 Term Life)

$ _____ Premium

Total Term Life SafeGuard Policy Fee $ _____

Initial Monthly Payment with Application $ _____

If Quarterly, Initial Monthly Payment with Application x 3 $ _____

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SECTION 3

Underwriting Questions – Must be completed

		If Yes, Who?
1. During the past 12 months, has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute?	☐ Yes ☐ No	
2. Is any applicant currently using supplemental oxygen?	☐ Yes ☐ No	
3. During the past 12 months, has any applicant:		
a. Been bedridden or confined to a hospital? If yes, provide details: _____ _____ _____	☐ Yes ☐ No	
b. Been confined to a nursing home, mental facility, inpatient rehabilitation, subacute facility, or hospice?	☐ Yes ☐ No	
c. Been diagnosed with, received medical care from a member of the medical profession for, or experienced seizures?	☐ Yes ☐ No	
d. Applied for, received, or currently receiving disability benefits from any insurance company, government, employer, or other source other than for maternity?	☐ Yes ☐ No	
e. Received medical care from a member of the medical profession for a condition that has yet to be diagnosed?	☐ Yes ☐ No	
f. Been advised to undergo any test (except HIV test), treatment, hospitalization, or surgery which has not yet been completed or for which results have not yet been received?	☐ Yes ☐ No	
4. During the past 10 years, has any applicant been diagnosed with or received medical care from a member of the medical profession for any of the following:		
a. Heart attack, cardiomyopathy, bypass/stents/angioplasty, atrial fibrillation, implant of pacemaker/defibrillator, heart surgery (including valve replacement or correction), or congestive heart failure?	☐ Yes ☐ No	
b. Stroke/transient ischemic attack (TIA), thrombosis, embolism, or hemophilia?	☐ Yes ☐ No	
c. Chronic Obstructive Pulmonary Disease (COPD) or chronic lung disease, emphysema, sarcoidosis, or pulmonary fibrosis?	☐ Yes ☐ No	
d. Diabetes (except gestational diabetes), organ transplant (or awaiting an organ transplant), chronic kidney disease or disorder (not including stones), chronic liver disease including cirrhosis, Hepatitis B, or Hepatitis C?	☐ Yes ☐ No	
e. AIDS, ARC, HIV infection, or any AIDS related condition?	☐ Yes ☐ No	
f. Any cancer (excluding basal cell or squamous cell skin cancer), Carcinoma In Situ, leukemia, Hodgkin's or Non-Hodgkin's Lymphoma, Alzheimer's or Senile Dementia?	☐ Yes ☐ No	
g. Paralysis, Multiple Sclerosis, Muscular Dystrophy, Amyotrophic Lateral Sclerosis (ALS or Lou Gehrig's Disease), or Parkinson's?	☐ Yes ☐ No	
5. During the past 24 months, has any applicant been diagnosed with, received medical care from a member of the medical profession for, or experienced symptoms of any of the following:		
a. Unexplained weight loss, fatigue, or dizziness?	☐ Yes ☐ No	
b. Recurrent breast tumors, unexplained tumors/growths, or abnormal pap smear without normal follow-up pap smear?	☐ Yes ☐ No	
c. Disorder of the heart or circulatory system, vascular insufficiency (circulatory problems), pulmonary hypertension, uncontrolled hypertension/high blood pressure, Renal Hypertension, chest pains, irregular heart beat, or tachycardia?	☐ Yes ☐ No	
d. Systemic Lupus Erythematosus (SLE) or Cystic Fibrosis?	☐ Yes ☐ No	
e. Schizophrenia, Bipolar Mood Disorder, Mood (Affective) Disorder, or currently taking anti-psychotic medication prescribed by a medical professional?	☐ Yes ☐ No	
6. Is any applicant employed in any of the following occupations:		
a. Transportation of hazardous materials; b. Demolition or any handling or transport of explosives; c. Logging industry (any outdoor occupation in this industry); d. Any offshore occupation in fishing, salvage, oil, or natural gas industry; e. Professional diving or diving attendants; f. Stunt, carnival or circus workers, or professional rodeo performers; g. Underground mining workers; h. Structural iron or steel workers (greater than 2 stories); i. Foreign travel required for missionary, diplomats, journalists, archaeologist, geologist, foreign, or volunteer aid worker?	☐ Yes ☐ No	

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

SECTION 3

Underwriting Questions – Must be completed *(continued)*

		If Yes, Who?
7. During the past 24 months, did any applicant engage in, or in the next 12 months, does any applicant plan to engage in, any of the following activities:		
a. Driving a motorcycle; b. Motorized racing (includes drivers, pit crew, owners, mechanics, speed test, or stunt show); c. Competitive skiing, snowboarding, biking, or skateboarding; d. Sky diving, parachute jumping, hang gliding, or parakiting; e. Skin or scuba diving (deeper than 60 feet and more than once per year); f. Rock/Mountain climbing; g. Student pilot (airplane, helicopter, glider, ultra-light); h. Pilot or crew member of a non-commercial aircraft (airplane, helicopter, glider, or hot air balloon)?	☐ Yes ☐ No	
8. During the past 5 years, has any applicant:		
a. Been convicted of a felony?	☐ Yes ☐ No	
b. Been convicted of driving under the influence of drugs or alcohol?	☐ Yes ☐ No	
c. Been convicted of reckless driving or had three or more moving violations?	☐ Yes ☐ No	
d. Had his/her driver's license suspended or revoked?	☐ Yes ☐ No	
9. During the past 10 years, has any applicant been diagnosed with or received medical care from a member of the medical profession for any of the following: Glaucoma or macular degeneration, hearing aids, cochlear implants, or similar devices used to enhance hearing, or Meniere's Disease?	☐ Yes ☐ No	
10. During the past 24 months, has any applicant been diagnosed with, received medical care from a member of the medical profession for, or experienced symptoms of any of the following: Total or partial loss of vision (except for prescription lenses used for vision correction), total or partial loss of hearing, or recurring or chronic tinnitus?	☐ Yes ☐ No	
11. Has any applicant been previously declined for critical illness insurance or lump sum benefit insurance for cancer or other specified conditions? If yes, provide details: _____	☐ Yes ☐ No	
12. Does any applicant intend to replace any existing life insurance or critical illness insurance?	☐ Yes ☐ No	
If yes, Who: _____ Company Name: _____ Policy Number: _____ If yes, Who: _____ Company Name: _____ Policy Number: _____		
13. During the past 5 years, has any applicant been treated by a physician or advised by a physician to seek treatment for drug or alcohol abuse or addiction?	☐ Yes ☐ No	

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

SECTION 4

General 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. This Statement of Understanding section will become part of the application. I understand and agree that:

(1) There will be no benefits for any loss incurred in the first 12 months of coverage due to a preexisting condition.

(2) Golden Rule Insurance Company (GRIC) may request additional information, and this may delay the processing of this application. If the health care provider charges a fee for these services, GRIC will determine its payment, and I will be responsible for any difference.

(3) GRIC has the right to rely upon the answers and statements in this application, without requesting medical records from any provider.

(4) This application and the initial payment do not give me immediate coverage.

(5) I should not terminate existing coverage until I have accepted the GRIC coverage.

(6) Incorrect or incomplete information on this application may result in voidance of coverage and/or claim denial.

(7) This completed application, and any supplements or amendments, will be a part of any policy or policies, if issued.

(8) The producer may only submit the application and initial payment, and may not promise me coverage, modify GRIC's underwriting policy or terms of coverage, or change or waive any right or requirement.

(9) The producer may receive copies of any correspondence about my medical history when correspondence is required.

(10) I must notify GRIC 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 applicants.

(12) If GRIC rejects this application, under no circumstances will any benefits be payable. Receipt of money, cashing of my check, or charging my credit card by GRIC does not constitute approval of my application or create GRIC coverage.

(13) I have received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

(14) **THIS PRODUCT PROVIDES LIMITED BENEFITS. THIS IS NOT MAJOR MEDICAL OR COMPREHENSIVE HEALTH INSURANCE, AND DOES NOT PROVIDE THE MANDATED COVERAGE NECESSARY TO AVOID PENALTY UNDER THE AFFORDABLE CARE ACT.**

X _____ Proposed Insured's Signature

X _____ Date signed and read application and product brochure

X _____ Spouse's Signature

X _____ Date signed and read application and product brochure

TL-AP-150-GRI-24

Payor Information (If other than Proposed Insured)

( )
_____
Contact Number

Mail completed application and initial premium to:
Golden Rule Insurance Company
PO Box 31370
Salt Lake City, UT 84131-0370

Jul 21 2016 03:27:04 pm

Payment

Initial Payment Method With Application – Select One Below

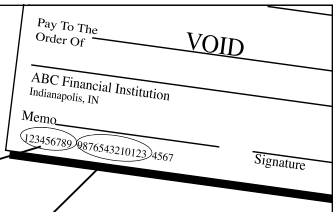
☐ **EFT** — Complete EFT Authorization below (EFT is only available with Monthly Initial Payment)
☐ **Credit Card** — Complete Credit Card Authorization below
☐ **Check** — Made payable to Golden Rule Insurance Company

Ongoing Payments – Select One Below

☐ Monthly EFT
☐ Monthly Credit Card
☐ Quarterly Direct Bill
☐ Semi-Annual Direct Bill
☐ Annual Direct Bill

Electronic Funds Transfer (EFT) and Credit Card payments will be collected at the time of application. If Initial Payment is EFT, Ongoing Payment must be EFT. If you choose Check as your Initial Payment Method, please mail your check with your completed application - checks are deposited upon receipt. Premium will be verified and may be adjusted up or down during the processing of your application.

☐ **ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION – ONLY IF PAYING BY EFT:**



I (we) hereby authorize Golden Rule Insurance Company 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

Only select a draft date between the 1st and 28th of the month.

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

☐ **CREDIT CARD AUTHORIZATION – ONLY IF PAYING BY CREDIT CARD:**

I authorize Golden Rule Insurance Company to bill my American Express/MasterCard/Visa account.
If quarterly billing requested, the Initial Payment will be for three months.

Type of Card: ☐ MasterCard ☐ Visa ☐ American Express Exp. Date: _____ _____
Month Year

Billing ZIP Code: _____ Card Number: _____

X_____ Charge On _____
Signature of Authorized User Day

Only select a charge date between the 1st and 28th of the month.

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

Final Authorizations

Producer 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 Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

X _____ X _____

Signature of Licensed Producer | Print Full Name

Producer Number

Authorization to Obtain and Disclose Nonmedical Information

I authorize Golden Rule Insurance Company's (GRIC) New Business and Medical History Review 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 GRIC's New Business and Medical History Review departments.

GRIC may also release this information about my family or me to the MIB or any member company for the purposes described in GRIC's Notice of Privacy Practices.

I (we) have received GRIC's Notice of Privacy 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 GRIC. I (we) may request revocation of this authorization by writing to GRIC, as explained in GRIC's Notice of Privacy Practices. GRIC 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 above: Authorization to Obtain and Disclose Nonmedical Information.

Signed X ___/___/___
Date

X _____
Signature of Primary Applicant (You)

X _____
Signature of Spouse (If to be covered)

051F-G-0816

Authorization to Obtain and Disclose Health Information

I authorize Golden Rule Insurance Company's (GRIC) New Business and Medical History Review departments to obtain health information that they need to underwrite or verify my application for insurance. Any health care provider, pharmacy benefit manager, 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 GRIC's New Business and Medical History Review 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.

GRIC may release this information about my family or me to the MIB or any member company for the purposes described in GRIC's Notice of Privacy Practices.

I (we) have received GRIC's Notice of Privacy 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 GRIC;
- I (we) may request revocation of this authorization as described in GRIC's Notice of Privacy Practices;
- GRIC 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.

052F-G-0816

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

Signed X ___/___/___
Date

X _____
Signature of Primary Applicant (You)

X _____
Signature of Spouse (If to be covered)

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

GOLDEN RULE INSURANCE COMPANY ▪ 7440 WOODLAND DRIVE ▪ INDIANAPOLIS, INDIANA 46278-1719

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

Replacing Your Life Insurance Policy?

Are you thinking about buying a new policy and discontinuing or changing an existing policy? If you are, your decision could be a good one – or a mistake. You will not know for sure unless you make a careful comparison of your existing policy and the proposed policy.

Make sure you understand the facts. Ask the company or insurance producer that sold you your existing policy to provide you with a policy summary statement.

Read the check list below of some of the items you should consider in making your decision. TAKE TIME TO READ IT.

Do not let one insurance producer or insurer prevent you from obtaining information from another insurance producer or insurer which may be to your advantage.

Hear both sides before you decide. This way you can be sure you are making a decision that is in *your* best interest.

We are required to notify your existing company that you may be replacing their policy.

ITEMS TO CONSIDER

1. If the policy coverages are basically similar, premiums for a new policy may be higher because rates increase as your age increases.
2. Cash values and dividends, if any, may grow slower under a new policy initially because of the initial costs of issuing a policy.
3. Your present insurance company may be able to make a change on terms which may be more favorable than if you replace existing insurance with new insurance.
4. If you borrow against an existing policy to pay premiums on a new policy, death benefits payable under your existing policy will be reduced by the amount of any unpaid loan, including unpaid interest.
5. Current interest rates are not guaranteed. Guaranteed interest rates are usually considerably lower than current rates. What rates are guaranteed?
6. Are premiums guaranteed or subject to change – up or down?
7. Participating policies pay dividends that may materially reduce the cost of insurance over the life of the contract. Dividends, however, are not guaranteed.
8. CAUTION, you are urged not to take action to terminate, assign, or alter your existing life insurance coverage until after you have been issued the new policy, examined it, and have found it to be acceptable to you.

REMEMBER, you have twenty (20) days following receipt to examine the contents of any individual life insurance policy or annuity. If you are not satisfied with it for *any* reason, you have the right to return it to the insurer at its home or branch office, or to the insurance producer through whom it was purchased, for a full refund of premium.

_____ _____

Applicant's Signature Date

Applicant's Name and Address *(Printed)*

_____

_____

_____

_____ _____

Insurance Producer's Signature Date

Insurance Producer's Name, Address, Telephone Number and License Number *(Printed)*

_____

_____

_____

NOTICE TO APPLICANT REGARDING REPLACEMENT OF LIFE INSURANCE OR ANNUITIES

GOLDEN RULE INSURANCE COMPANY ▪ 7440 WOODLAND DRIVE ▪ INDIANAPOLIS, INDIANA 46278-1719

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4. If you borrow against an existing policy to pay premiums on a new policy, death benefits payable under your existing policy will be reduced by the amount of any unpaid loan, including unpaid interest.
5. Current interest rates are not guaranteed. Guaranteed interest rates are usually considerably lower than current rates. What rates are guaranteed?
6. Are premiums guaranteed or subject to change – up or down?
7. Participating policies pay dividends that may materially reduce the cost of insurance over the life of the contract. Dividends, however, are not guaranteed.
8. CAUTION, you are urged not to take action to terminate, assign, or alter your existing life insurance coverage until after you have been issued the new policy, examined it, and have found it to be acceptable to you.

REMEMBER, you have twenty (20) days following receipt to examine the contents of any individual life insurance policy or annuity. If you are not satisfied with it for *any* reason, you have the right to return it to the insurer at its home or branch office, or to the insurance producer through whom it was purchased, for a full refund of premium.

_____ _____

Applicant's Signature Date

Applicant's Name and Address *(Printed)*

_____

_____

_____

_____ _____

Insurance Producer's Signature Date

Insurance Producer's Name, Address, Telephone Number and License Number *(Printed)*

_____

_____

_____

200F-G **Applicant's Copy** 0816