APPLICATION FOR DENTAL/VISION INSURANCE
GOLDEN RULE INSURANCE COMPANY — INDIANAPOLIS, INDIANA

PLEASE PRINT IN BLUE INK

APPLICANT(S) INFORMATION

PROPOSED INSURED: ______ First Name ______ Middle Initial ______ Last Name ______ Birth Date: Month ___ Day ___ Year ___ Age ___ Gender ☐ Male ☐ Female

Mailing Address: Street (Include Apt.) ______

City ______ State ______ ZIP ______

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 ______

Phone Numbers: ( ) ______ Home ( ) ______ Other ______ Best number and times to call ______ E-mail Address ______

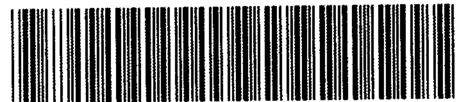
DEPENDENTS: List below any dependents to be covered under the policy.

Name (Last, First, M.I.)	Relationship	Birth Date	Gender
	Spouse	/ /	☐ M ☐ F
		/ /	☐ M ☐ F
		/ /	☐ M ☐ F
		/ /	☐ M ☐ F
		/ /	☐ M ☐ F
		/ /	☐ M ☐ F

PAYOR: (If not You): ______ Name ______ E-mail Address ______

Street ______ City ______ State ______ ZIP ______

		Yes	No
1.	Do you or does any applicant now have dental 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.)	☐	☐
2.	If you are applying for vision insurance, do you or does any applicant now have vision 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.)	☐	☐
3.	Are you or any dependent intending to replace in force dental or vision (if applicable) insurance?	☐	☐



651D-G-0609

Jul 12 2009 12:00:08

REQUESTED EFFECTIVE DATE: _____/_____/______
(See Statement of Understanding section.)

Plan Choices: ☐ UnitedHealthcare Dental Premier℠ ☐ UnitedHealthcare Dental Value℠ (if available)

OPTIONAL: ☐ UnitedHealthcare Vision

Payment Mode: ☐ Monthly ☐ Quarterly ☐ Semi-annual ☐ Annual

Payment Options: **Initial Payment with Application:** ☐ Check ☐ EFT ☐ Credit Card

Ongoing Payments: ☐ Monthly EFT ☐ Direct Bill ☐ List Bill (include forms; $25 monthly admin. fee per list bill group)

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) if other dental/vision insurance exists that duplicates coverage under the dental/vision plan being applied for, the existing dental/vision coverage must be terminated prior to the effective date of this coverage; (c) if coverage is issued, the coverage will not be a continuation of any prior coverage; and (d) the policy being applied for may contain waiting periods for certain benefits listed on the policy Data Page. 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 CT
State where you signed this application

X ______________________________
Date you signed and read application

X John G. Karavas
Licensed Agent or Broker (Please print.)

X 2273412
Individual Producer Number

IMPORTANT NOTES: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service. No application will be accepted if received by Golden Rule more than 15 days after the date signed. Altered applications will not be accepted.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

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

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

According to your application or information you have furnished, you intend to lapse or otherwise terminate existing accident and sickness insurance and replace it with a policy to be issued by Golden Rule Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. Health conditions which you may presently have (preexisting conditions) may not be immediately or fully covered under the new policy. This could result in denial or delay of a claim for benefits under the new policy, whereas a similar claim might have been payable under your present policy.
2. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.
3. If, after due consideration, you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical/health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premium as though your policy had never been in force. After the application has been completed and before you sign it, re-read it carefully to be certain that all information has been properly recorded.

Also, if you are issued coverage, carefully check the application again and write to Golden Rule Insurance Company at the address shown at the top of this notice within 10 days if any information is not correct and complete, or if any past medical history has been left out of the application.

The above "Notice to Applicant" was delivered to me on:

____
Applicant's Signature

____
Date

594D-G

Golden Rule's Copy

0808

CONTINUE WITH PAYMENT INFORMATION ON NEXT PAGE

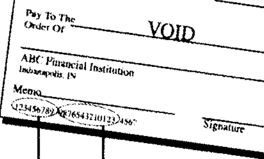
Mail completed application to:
Golden Rule Insurance Company
DENTAL APPLICATION
PO Box 68994
Indianapolis, IN 46268-0994

Jul 12 2009 12:00:08

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. ________

Acct 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

E-mail Address ________

INITIAL PAYMENT CREDIT CARD AUTHORIZATION

I authorize Golden Rule to bill my MasterCard/Visa account for the Total Premium for Mode Chosen.*

Type of Card: ❑ MasterCard ❑ Visa Exp. Date: ____ Month ____ Year

Card Number: ________

X ________

Signature of Authorized User

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

CALCULATE YOUR PREMIUM

❶ CONNECTICUT DENTAL BASE RATES

UnitedHealthcare *Dental Premier*	1 Person	2 People	3+ People
Statewide	42.48	84.11	148.68
UnitedHealthcare *Dental Value*			
Statewide	25.52	50.53	89.32

❷ TREND FACTORS

Effective Dates	Factor
July through September 2009	1.045
October through December 2009	1.060
January through March 2010	1.075
April through June 2010	1.090

❸ CONNECTICUT VISION RATES

Statewide	9.00	16.00	24.00

❹ PAYMENT MODE FACTORS

Modes	Factor
Monthly	1
Quarterly	3
Semi-annual	6
Annual	12

PREMIUM CALCULATION		
Dental Base Rate for Plan Chosen ❶		____
Trend Factor ❷	x	____
Subtotal	=	____
Vision Rate ❸	+	____
Subtotal	=	____
Payment Mode Factor ❹	x	____
Premium for Mode Chosen*	=	____

*The amount charged to your credit card will be the total amount for the payment mode chosen (Monthly, Quarterly, Semi-annual, or Annual).

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