Select a plan, coverage period from 1 to 6 months, and a deductible that fits your budget.

Short Term Medical℠ Plus

- Offers more coverage than our Value plan. Great for those seeking predictable out-of-pocket expenses.
- You select the length of coverage (term) you need, from 1 to 6 months, and the **deductible** amount (you pay) **for the selected time period**.

Short Term Medical℠ Value

- Costs less than our Plus plan. In exchange, you take more responsibility for medical expenses.
- You select the length of coverage (term) you need, from 1 to 6 months, and the **deductible** amount (you pay) **for EACH illness or injury** (cause).

Why Choose Us for Health Insurance?

UnitedHealthcare

Approximately 25 million customers entrust UnitedHealthcare with their health insurance needs.* Our network plans can ease access to high-quality care from physicians and hospitals nationwide. Together, we combine our strength and stability with nearly three decades of experience serving customers of all sizes.

UnitedHealthOne

UnitedHealthOne is the brand name of the UnitedHealthcare family of companies that offers personal health insurance products. Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter and administrator of these plans. With over 60 years of experience serving individuals and families, Golden Rule provides high-quality products, timely claims handling, and outstanding customer service.

Experience and Expertise

Golden Rule's experience and expertise has driven the development of easy-to-use and innovative health insurance products. A recognized leader — and one of the nation's largest providers of health savings account plans — Golden Rule continues building plans that meet the needs of individuals and families.

026E-G-1110

* UnitedHealth Group Annual Form 10-K for year ended 12/31/09.

1) Ohio Monthly Base Premium Rates

Short Term Medical℠ Plus

Age	$250 Deductible Male	$250 Deductible Female	$500 Deductible Male	$500 Deductible Female	$1,000 Deductible Male	$1,000 Deductible Female	$1,500 Deductible Male	$1,500 Deductible Female	$2,500 Deductible Male	$2,500 Deductible Female	$5,000 Deductible Male	$5,000 Deductible Female	$10,000 Deductible Male	$10,000 Deductible Female
To 24	70	65	45	42	32	28	29	25	23	20	18	16	15	13
25-29	70	73	45	48	33	33	29	30	23	24	19	19	15	15
30-34	74	84	49	56	35	39	31	35	25	28	20	22	16	18
35-39	78	96	53	63	37	44	33	39	27	31	21	25	17	20
40-44	96	111	65	73	48	51	43	46	34	37	27	29	22	24
45-49	116	127	78	85	59	62	53	56	42	44	34	36	28	29
50-54	146	148	100	101	77	77	69	69	55	55	44	44	36	36
55-59	195	175	134	120	105	94	94	84	75	67	60	54	49	43
60-64	241	200	165	136	129	107	115	95	92	76	74	61	60	50
Per Dependent Child**	35	35	23	23	15	15	13	13	11	11	8	8	7	7

Short Term Medical℠ Value

Age	$250 Deductible Male	$250 Deductible Female	$500 Deductible Male	$500 Deductible Female	$1,000 Deductible Male	$1,000 Deductible Female	$1,500 Deductible Male	$1,500 Deductible Female	$2,500 Deductible Male	$2,500 Deductible Female	$5,000 Deductible Male	$5,000 Deductible Female
To 24	57	54	37	34	26	23	23	20	18	16	14	13
25-29	58	61	37	39	26	27	23	24	18	19	15	15
30-34	61	70	40	45	28	32	25	28	19	22	15	17
35-39	65	79	43	52	30	35	27	31	21	25	17	20
40-44	80	91	53	60	39	41	35	37	27	29	21	23
45-49	96	105	64	69	48	50	43	45	33	35	27	28
50-54	121	122	82	82	62	63	55	56	43	43	35	35
55-59	161	145	109	98	85	76	76	67	59	52	47	42
60-64	199	165	135	111	104	86	93	77	72	60	58	48
Per Dependent Child**	29	29	19	19	12	12	11	11	8	8	7	7

Child(ren) rates without Parents. If you are calculating rates for one child without parents, use the Male or Female "To 24" rate for the child. For two or more children without parents, use the Male or Female "To 24" rate for the youngest child and add the "Per Dependent Child" rate for each additional child.

3) Trend Factor

Effective Date	Trend Factor
November 2010 - March 2011	1.120
April 2011 and later	1.160

4) ZIP Code Area Factor

ZIP Code	Factor
430-433, 449, 453-455, 457	1.150
434-436, 442, 450	1.275
437-439, 451, 452, 456, 458	1.450
440, 441	1.400
443, 446-448	1.225
444, 445	1.375

026E-G-1110

Please read the Short Term Medical[SM] plans brochure and this separate, state-specific application and payment information thoroughly and carefully.

Premium Calculation Instructions

Instructions	Calculation	Monthly Payments	Single Payment
1) Monthly Base Premium Rate. In the tables to the left, find the appropriate rate for each person applying. Rates are based on selected plan, deductible, and age (as of requested effective date). If parents are not applying, see ****Child(ren) rates without Parents.**	**1)** Find Your Rate *(see chart on left)* **a)** Your Rate .... **b)** Spouse Rate.... **c)** Child Rate *(no. of children ____ x $____)* .... **Subtotal =**	________ + ________ + ________ ________	
2) Multiple Person Discount. If you are the only person applying, multiply Subtotal by 1.00. If more than one is applying, multiply Subtotal by 0.90.	**2)** Multiple Person Discount.... ***(1 person = 1.00) (2 or more = .90)*** **Subtotal =**	**x** ________ ________	
3) Trend Factor. Your effective date determines the Trend Factor. Use the chart on left and multiply Subtotal.	**3)** Trend Factor *(see chart on left)*.... **Subtotal =**	**x** ________ ________	
4) ZIP Code Area Factor. Multiply Subtotal by ZIP Code Area Factor chart on left.	**4)** ZIP Code Area Factor *(see chart on left)* .... **Subtotal =**	**x** ________ ________	
<u>Two Payment Options:</u> *You can choose* **Monthly Payments** *or* **Single Payment.** **5)** For Monthly Payment option only, multiply by 1.15.	**5)** Monthly Processing Factor *(if paying monthly)*.... **Subtotal =**	**x 1.15** ________	**N/A** **N/A**
6) You must become a member of FACT to apply for a *Short Term Medical* plan, and pay **monthly membership fee**. Please complete **FACT Membership Enrollment Form**.	**6)** FACT Membership Dues *(per month)*.... ☐ Basic $4 ☐ Choice $20 ☐ Elite $40 **Subtotal =**	**+** ________ ________	**+** ________ ________
7) For Single Payment Option only – multiply by number of months you want coverage.	**7)** Number of Months *(if applicable) (1 to 6)*.... **Subtotal =**	**N/A** ________	**x** ________ ________
8) One-Time Nonrefundable Application Fee. (Additional Payments will not include this fee.)	**8)** $20 Application Fee *(one-time fee)*.... **Total Payment Payable to FACT =**	**+ $20.00** **$** ________ **Total Initial Payment**	**+ $20.00** **$** ________ **Total Single Payment**

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 FACT, or complete the **Single Payment: Credit Card** section on the other side if you are paying by credit card.

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

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

RESIDENT ADDRESS ______ Street City State ZIP ( ) Telephone No.

1. Are any of your dependents to be covered under the policy/certificate? ☐ **Yes** ☐ **No** If Yes, give details below.

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/certificate.

	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 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/certificate.)	☐	☐
4. Have you or 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/certificate.)	☐	☐
5. Do you or 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/certificate.)	☐	☐
6. Within the last 5 years, have you or 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/certificate.)	☐	☐

PLAN: ☐ **Short Term Medical℠ Plus** ☐ **Short Term Medical℠ Value** **REQUESTED EFFECTIVE DATE:** ____/____/____

DEDUCTIBLE: ☐ $ 250 ☐ $ 500 ☐ $ 1,000 ☐ $ 1,500 ☐ $ 2,500 ☐ $ 5,000 ☐ $ 10,000 (not available with Short Term Medical℠ Value)

MONTHS OF COVERAGE: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6

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 at its Lawrenceville or Indianapolis Office with this application; (b) no benefits will be paid for a health condition that exists 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/certificate which 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 at its Lawrenceville or Indianapolis Office. 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

______ Licensed Agent or Broker (Please Print)

______ Individual Producer #

The state of Ohio requires that we provide you with the following information: Any person who, with intent to defraud or knowing that he or she is facilitating a fraud against an insurer, submits an application or files a claim containing a false or deceptive statement is guilty of insurance fraud.

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.

Note: P.O. Boxes are not accepted for the Resident Address.

To Continue Your Application for Coverage, You Must Become A Member Of FACT

Read and fill out the following FACT Membership Enrollment Form.

FACT MEMBERSHIP ENROLLMENT FORM

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 Application for Short Term Medical 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.

X ______________________________ Member's Signature ______________ Date

Email Address: ______________________________

If you wish to apply for association group health insurance, please complete the application.

FACT ENFO STM 1110

PAYOR INFORMATION (If other than Proposed Insured)

Payor: ______________________________

Name E-mail 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 nonrefundable application fee.)
For this method of payment, you must make check or money order payable to FACT. (EFT available with online application)

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

Credit Card Authorization ☐ Visa ☐ MasterCard

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

Account No. ____/____/____ Expiration Date X ______________ Signature of Authorized User

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

OR

☐ **Monthly Payment:**

Initial Payment ☐ Check or money order ☐ EFT (online application only)
$ Amount __________ (Total Initial Payment on reverse. First month amount (shown) includes a one-time $20 nonrefundable application fee.)

Ongoing Payments (Choose one)

☐ **Direct Bill** ($10 monthly billing fee)
Additional monthly Direct Bill payments will not include the $20 application fee, however they will include a $10 monthly billing fee.

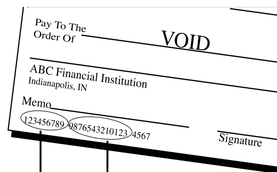
☐ **Electronic Funds Transfer** (EFT) (no billing fee)
Additional monthly EFT payments will not include the $20 application fee. For this method of payment, you must complete the EFT Authorization below.

ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION — ONLY IF PAYING BY EFT

I (we) hereby authorize 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

X ______________ Authorized Account Signature

E-mail 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.