

# Hatcher & Associates

## 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 Hatcher & Associates for review along with the completed application. If you do not have access to a fax machine, send the completed application to Hatcher & Associates 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 sign and date the authorization form.

Don't forget to **enclose the initial premium and FACT dues check made payable to "FACT"**.

Mail completed application and check to:

**Hatcher & Associates**

**Attn: New Enrollment**

**356 Rufener St.**

**Rittman, OH 44270**

Hatcher & Associates 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 888-925-3874 or e-mail us at [lifeagent@neo.rr.com](mailto:lifeagent@neo.rr.com).

# Hatcher & Associates

## 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:**

**Hatcher & Associates**

**FAX# 330-925-2923**

Dear Hatcher & Associates,

Please accept my completed insurance 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 Hatcher & Associates at 888-925-3874 to verify receipt of my application.

**\*\*I understand that Hatcher & Associates will not review this application until the following weekday morning if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to Hatcher & Associates. I will mail the original signed application to :

**Hatcher & Associates**

**Attn: New Enrollment**

**356 Rufener St.**

**Rittman, OH 44270**

I will send the original application as soon as I have been contacted by Hatcher & Associates with confirmation that my application has been received by fax and reviewed for completeness.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

**FACT MEMBERSHIP ENROLLMENT FORM (If not already a member)**

I hereby enroll for Full Associate membership in the FEDERATION OF AMERICAN CONSUMERS AND TRAVELERS (FACT). Upon completion of this enrollment form and payment of initial dues (\$3 monthly), I understand that: (a) I will be entitled to FACT's benefits; (b) these benefits may change from time to time; (c) my membership will become effective on the day this enrollment form is dated and signed; (d) I am eligible to apply for association group insurance; and (e) I authorize the release of my name and address listed on the Golden Rule Insurance Company Application for Insurance to FACT.

Member's Signature X \_\_\_\_\_ Date X \_\_\_\_\_

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

FACT ENFO 0304

**Warning:** If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Before you enroll in this plan, read all of the rules very carefully and compare them with the rules of any other plan that covers you or your family.

**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							
Name (Last, First, M.I.)			Birth Date	Age	Sex	Height	Weight
a.	Not Required						
b.							
c.							
d.							
e.							

4. Primary Applicant's Address (P.O. Boxes are not accepted.)  
 \_\_\_\_\_  
 Street City State ZIP

5. Phone Numbers: ( ) Daytime ( ) Evening Best times to call

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): \_\_\_\_\_  \$15,001 to \$35,000  \$50,001 to \$75,000  \$100,000 or more



Notice: The state of Ohio requires that we provide you with the following information: Any person who, with intent to defraud or knowing that he 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.

## DRIVING

- Yes No
16. In the last 24 months, has any applicant participated in driving any type of motorcycle? .....
- If yes, please answer the following questions:**
- a. Name of applicant(s)? \_\_\_\_\_
- b. Does the applicant have a valid motorcycle license? .....
- c. Within the last 24 months, has the applicant had his/her license suspended or revoked? .....
- 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." .....

## MEDICAL HISTORY -- FOR ALL APPLICANTS

IMPORTANT! PLEASE PROVIDE DETAILS OF EACH YES ANSWER IN "MEDICAL HISTORY DETAILS."

- |   | Yes                      | No                       |   | Yes                      | No                       |
|---|--------------------------|--------------------------|---|--------------------------|--------------------------|
| 17. Is any family member (whether or not named in this application) pregnant or an expectant mother or father? .....                                      | <input type="checkbox"/> | <input type="checkbox"/> | 23. <b>In the last 10 years, has any applicant:</b>   |                          |                          |
|   |                          |                          | a. had a complicated pregnancy or delivery? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 18. Do any applicants, other than dependent children, <b>not</b> read, write, speak, and understand the English language? .....                           | <input type="checkbox"/> | <input type="checkbox"/> | b. tested positive for antibodies to the HIV virus? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 19. Do you have an adoption pending? .....  | <input type="checkbox"/> | <input type="checkbox"/> | c. been hospital confined, had surgery, or discussed surgery? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| 20. <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"/> | 24. <b>In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:</b>  |                          |                          |
| 21. <b>Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:</b>    |                          |                          | a. heart or circulatory system? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| a. gallbladder? .....   | <input type="checkbox"/> | <input type="checkbox"/> | b. nervous system? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| b. pancreas or liver? .....   | <input type="checkbox"/> | <input type="checkbox"/> | c. digestive system? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| c. joints or spine? .....   | <input type="checkbox"/> | <input type="checkbox"/> | d. muscular or skeletal system? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| d. kidney? .....  | <input type="checkbox"/> | <input type="checkbox"/> | e. respiratory system? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| e. eyes, ears, or nose? .....   | <input type="checkbox"/> | <input type="checkbox"/> | f. male or female reproductive system, including infertility? .....   | <input type="checkbox"/> | <input type="checkbox"/> |
| f. mouth, throat, or jaw? .....   | <input type="checkbox"/> | <input type="checkbox"/> | g. urinary system? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| 22. <b>In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:</b>                                       |                          |                          | h. thyroid, breast, or other glands? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| a. high blood pressure? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 25. In the last 10 years, has any applicant had any 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"/> |
| b. chest pain? .....  | <input type="checkbox"/> | <input type="checkbox"/> | 26. 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"/> |
| c. headaches? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 27. 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"/> |
| d. paralysis? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 28. 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"/> |
| e. arthritis? .....   | <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).   |                          |                          |
| f. convulsions or epilepsy? .....   | <input type="checkbox"/> | <input type="checkbox"/> | 29. 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 10.) .....                      | <input type="checkbox"/> | <input type="checkbox"/> |
| g. elevated cholesterol? .....  | <input type="checkbox"/> | <input type="checkbox"/> | 30. 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.                    |                          |                          |
| 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. Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness? .....  | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| m. tumor, cyst, polyp, lump, or growth of any kind? .....   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |
| n. mental, emotional, or behavioral disorder? .....   | <input type="checkbox"/> | <input type="checkbox"/> |   |                          |                          |



**MONTHLY P.A.C. AUTHORIZATION -- ONLY IF PAYING BY MONTHLY P.A.C.**

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 from me (or either of us) of its termination.

Checking Account No. \_\_\_\_\_

X \_\_\_\_\_

(Signature of Payor, If not You)

Financial Institution's Name \_\_\_\_\_

Address \_\_\_\_\_

City, State, ZIP \_\_\_\_\_

Draft On \_\_\_\_\_

Day

X \_\_\_\_\_ **Attach Voided BLANK check here!**

(Date Signed)

**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 person, employer, insurance company, consumer-reporting agency, or the Medical Information Bureau (MIB) having nonmedical information about 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 above: Monthly P.A.C. Authorization, Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.**

Signed X \_\_\_\_\_ at \_\_\_\_\_  
 Date 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 \_\_\_\_\_  
 Date 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 Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

I agree with the answer given for Question 13, "Will the term life benefit replace any existing life insurance?" (If the response shown for Question 13 does not reflect your understanding, please check this box and attach an explanation. )

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

417684416

Broker Number

X Don Hatcher  
Print Full Name

**HEALTH SAVINGS ACCOUNT (HSA) AGREEMENT AND ADOPTION (only if depositing HSA money with Golden Rule)**

I wish to establish an HSA with Golden Rule as custodian and direct that my contributions be deposited in my Golden Rule HSA. I adopt the current Golden Rule Custodial Agreement and agree to its terms.

I understand the following:

- 1) Golden Rule has no responsibility for the tax treatment of my HSA.
- 2) I may revoke the HSA Custodial Agreement for any reason within seven days after I receive a copy of the Custodial Agreement.
- 3) If the Custodial Agreement is revoked by me, I will not be charged a set-up fee nor any monthly fees and agree that no interest will be paid on the money returned.
- 4) My Golden Rule HSA will credit interest on money in my account.
- 5) Golden Rule will set up my account and begin crediting interest the later of: a) 10 days after issue of the qualified medical insurance; or b) the effective date of my qualified medical insurance.
- 6) Interest will not begin to accrue until funds are deposited with Golden Rule's agent bank.

7) Golden Rule or its agent bank may deduct usual administrative fees from my account and these fees may change on 60 days' prior notice.

8) The Custodial Agreement and Disclosure Notice are subject to change and may be changed as necessary to comply with the law.

The primary insured on the qualified Golden Rule medical insurance will be the accountholder of this HSA. If my spouse has signed this agreement, I authorize my spouse to withdraw funds from my HSA.

**Required Certification:** Under penalties of perjury, I certify that (1) my Social Security number shown on the application is correct; and (2) I am not subject to backup withholding and elect not to have any withholding apply. (Cross out and initial (2) if you have been notified that you were subject to backup withholding.)

Have you, within the last 6 months, been covered under another health insurance plan?  Yes  No Has your spouse?  Yes  No  
If not applying for health insurance, but authorized to withdraw HSA Funds:

Spouse's Social Security Number \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Spouse's Date of Birth \_\_\_\_\_

X \_\_\_\_\_  
Signature of Primary Applicant

X \_\_\_\_\_  
Signature of Spouse

**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 (UHC), you must still fully complete this application accurately. Our underwriters do not have access to UHC 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 Illustration.
- Initial premium and FACT dues check made payable to "FACT."
- P.A.C. authorization and voided check (if paying monthly).

**Mail to:** Golden Rule Insurance Company  
HEALTH APPLICATION  
Home Office  
712 Eleventh Street  
Lawrenceville, Illinois 62439-2395