APPLICATION FOR SHORT TERM MEDICAL INSURANCE
GOLDEN RULE INSURANCE COMPANY
INDIANAPOLIS, INDIANA 46278-1719

Please list only those persons needing coverage.

Applicant(s) Information

Gender	Name (Last, First, M.I.)	Social Security Number	Birth Date*	MUST BE ACCURATE** Height	Weight
☑ Male ☐ Female	Primary (You) Chitra Raja I Kiran Mohan	* * * - * * - * * * 5	10 26 88	5' 7"	178
☐ Male ☐ Female	Spouse	- -			
☐ Male ☐ Female	Child 1				
☐ Male ☐ Female	Child 2				
☐ Male ☐ Female	Child 3				
☐ Male ☐ Female	Child 4				

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

**Applicants must meet our height and weight guidelines to qualify for coverage.

Resident Physical Address (where you live and pay taxes). PO Boxes are not accepted.

Street (Include Apt.)	City	State	ZIP Code
625 PARKWAY BLVD APT 1222	COPPELL	TX	75019

Mailing Address (if different than Resident Address)

Street (Include Apt.)	City	State	ZIP Code

Payor (if not you)

Name (Last, First, M.I.):	Relationship to Primary		
	☐ Relative ☐ Other (Specify):_____		
Street (Include Apt.)	City	State	ZIP Code

Contact Information

	Phone Number	Email	Applicant
Primary (You)	469 883-3249 ☐ Check if not a mobile phone.	mohankiran06@gmail.com	
Spouse			
Dependent Child age 18 and over			
Dependent Child age 18 and over			
Payor (if not you)	-		

Plan Selection

Requested Effective Date: 10 / 06 / 2022 *(See Statement of Understanding section)*			Months of Coverage: 6	
Plans *(Choose one plan)*	☐ **Premier Elite**	100/0 - $0	☐ **Copay**	80/20 - $5,000
	☐ **Plus Elite**	100/0 - $0	☑ Value	70/30 - $10,000
	☐ **Plus**	80/20 - $2,000	☐ Value **Direct**	60/40 - $10,000

Deductible Amount *(Choose one)*

- ☐ $2,500 - Available for Plus Elite, Plus, Copay, and Value plans only
- ☐ $5,000 - Available for all plans
- ☐ $7,500 - Available for Plus Elite, Plus, Copay, and Value plans only
- ☐ $10,000 - Available for Premier Elite, Plus Elite, Copay, and Value Direct plans only
- ☐ $14,000 - Available for Premier Elite only
- ☑ $15,000 - Available for Plus Elite, Plus, Copay, Value, and Value Direct plans only

Optional Benefits Selection

Supplemental Accident Benefit	☐ $2,500 ☐ $5,000 ☐ $7,500 ☐ $10,000 ☐ $15,000
Consecutive Short Term Plans	☐ (If this option is selected, a condition that began during the first Short Term Medical Expense policy/ certificate with us will not be a preexisting condition under later Short Term Medical Expense policies/ certificates with us during a continuous, uninterrupted period of coverage, as defined in the Consecutive Short Term Plans Rider.)
Virtual Care Rider	☐

Application Questions

	General Information	**Yes**	**No**
G1	During the past 5 years, has any applicant been declined for insurance by a carrier other than Golden Rule Insurance Company due to health reasons? If yes, select each person: ☐Primary ☐Spouse ☐Child 1 ☐Child 2 ☐Child 3 ☐Child 4 The person(s) named will not be covered under the policy/certificate.	☐	☑
G2	Has any applicant lived in the 50 states of the USA or the District of Columbia for less than the past 12 months? If yes, select each person: ☐Primary ☐Spouse ☐Child 1 ☐Child 2 ☐Child 3 ☐Child 4 The person(s) named will not be covered under the policy/certificate.	☐	☑
G3	During the past 12 months, has any applicant smoked cigarettes or e-cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute? If yes, select each person: ☐Primary ☐Spouse ☐Child 1 ☐Child 2 ☐Child 3 ☐Child 4	☐	☑
	Medical History Information	**Yes**	**No**
M1	Is any applicant currently pregnant, an expectant parent, in the process of adopting a child, or undergoing infertility treatment? If yes, coverage cannot be issued.	☐	☑
M2	Within the last 5 years, has any applicant received medical or surgical consultation, advice, or treatment, including medication, for any of the following: blood disorders, liver disorders, kidney disorders, chronic obstructive pulmonary disorder (COPD) or emphysema, diabetes, cancer, multiple sclerosis, heart or circulatory system disorders (excluding high blood pressure), Crohn's disease or ulcerative colitis, or alcohol or drug abuse or immune system disorders? If yes, select each person: ☐Primary ☐Spouse ☐Child 1 ☐Child 2 ☐Child 3 ☐Child 4 The person(s) named will not be covered under the policy/certificate.	☐	☑

Application Questions *(continued)*

M3	During the past 12 months, has any applicant been advised to undergo any test (except for HIV test), treatment, hospitalization, or surgery which has not yet been completed or for which results have not yet been received? If yes, select each person: ☐Primary ☐Spouse ☐Child 1 ☐Child 2 ☐Child 3 ☐Child 4 The person(s) named will not be covered under the policy/certificate.	☐	☑
M4	Within the last 5 years, has any applicant received treatment, advice, medication, or surgical consultation for HIV infection from a doctor or other licensed clinical professional, or had a positive test for HIV infection performed by a doctor or other licensed clinical professional? If yes, select each person: ☐Primary ☐Spouse ☐Child 1 ☐Child 2 ☐Child 3 ☐Child 4 The person(s) named will not be covered under the policy/certificate.	☐	☑
Other Coverage Information		**Yes**	**No**
O1	Does any applicant now have, or is any applicant currently applying for, other hospital or medical expense insurance that **will not** terminate prior to the requested effective date? If yes, provide the following details.	☐	☑

Type of Coverage (e.g. major medical, short term, critical illness)	Insurance Company Name	Applicants Covered	Planned Termination Date (if any)

For Applicants with Current Short Term Medical Coverage With Us		**Yes**	**No**
S1	Does any applicant currently have short term limited duration medical insurance coverage with Golden Rule Insurance Company that will **not** terminate prior to the requested effective date? If yes, please answer question a below.	☐	☑
	a. Do you want to terminate the current short term medical coverage the effective date of the new policy/certificate, if issued? If yes: i. Any illness, injury, or condition that began during the current coverage will be considered a preexisting condition under the new policy/certificate and may not be covered; and ii. Any deductible amount, coinsurance percentage and other amounts paid by you under your current coverage do **not** count toward the new policy/certificate. If you answer no to question S1a, the effective date of the new policy/certificate, if issued, will be the date your current short term medical coverage terminates.	☐	☐

This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your policy/certificate carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your policy/certificate might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

Statement of Understanding

I have read this application and represent that the information shown on it is true and complete. I understand that:

(1) No insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule with this application.

(2) No benefits will be paid for a health condition that exists prior to the date insurance takes effect.

(3) If coverage is issued, the coverage will not be a continuation of any prior coverage.

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

(5) The information provided in this application, and any supplement or amendments to it, will be made a part of any policy/certificate that may be issued.

(6) If my application is approved, insurance will be effective the later of: (a) the requested effective date, or (b) the effective date approved by Golden Rule.

(7) If other short term limited duration medical insurance is still active with Golden Rule for any applicant on that effective date, then the effective date of the new coverage, if issued, will be the date the current short term medical coverage terminates unless otherwise indicated in this application.

(8) The producer is only authorized to submit the application and initial premium and may not change or waive any right or requirement.

(9) If I have provided a phone number, Golden Rule may provide a welcome call. If I have provided a mobile phone number, Golden Rule may also text me (a) prior to the end of my short term medical coverage, (b) if my coverage lapses, and/or (c) if my premium is past due.

(10) The policy/certificate does not cover the charges for services received from a non-network provider, except for emergencies.

Signature Information		
	Signature	**Date Signed**
Proposed Insured (or Parent/Legal Guardian if Proposed Insured is a child)	Kiran Mohan Chitra Raja Mohan Nair (esig	10 05 22

Important Notes:

- No application will be accepted if received by Golden Rule more than 15 days after the date signed.
- Altered applications will not be accepted.

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 ($10 a month) 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 Kiran Mohan Chitra Raja Mohan Nair (esign)
Member's Signature

2022-10-05
Date

FACT ENFO STM 1221

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

Producer

X Unitedhealthone Direct Sales
Print Full Name

4005234
Producer Number

Payment Options: Single Payment or Monthly Payment

Electronic Funds Transfer (EFT) and Credit Card payments will be collected at the time of application. Premium will be verified and may be adjusted up or down during the processing of your application. Please select your payment option and then complete the authorization below. Amounts include monthly $10 FACT fee.

☐ **Single Payment** (one single payment for all months of coverage chosen):

- ☐ **EFT**
- ☐ **Credit Card**

Amount $ _____

OR

☑ **Monthly Payment**:

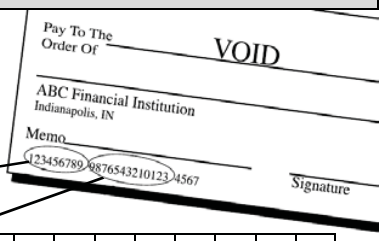
- ☐ **EFT**
- ☑ **Credit Card**

Amount $ 121.07

Electronic Funds Transfer Authorization - Complete only if paying by EFT

I (we) hereby authorize FACT or 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 - Complete only if paying by Credit Card

I authorize FACT or Golden Rule Insurance Company to bill my American Express/MasterCard/Visa/Discover account for the Single Payment or Monthly Payment above.

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

Billing ZIP Code: _____ Card Number _____

X Kiran Mohan Chitra Raja Mohan Nair (esi
Signature of Authorized User

Charge On 6
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.

Is this short-term health insurance plan right for me?

You must read and sign this form.

Plan name: Short Term Medical Value

$15,000 deductible, 30% coinsurance

Offered by: Golden Rule Insurance Company

This plan does not need to follow federal Affordable Care Act (ACA) rules. Unlike ACA plans, this short-term plan:

- May not cover all injuries or sicknesses, including any you have before applying.
- May not pay for some medical care you might need.
- Doesn't allow you to get federal help with premiums or out-of-pocket costs (tax credits and cost-sharing reductions).

Carefully read the information below so you know this plan's coverage limits and your rights under this plan.

How long will this plan cover me?

6 months

Can I renew or extend this plan?

No.

When this plan ends, can I sign up for another insurance plan?

- If you want to sign up for another short term health plan or another plan not covered by ACA laws: You can sign up for another plan at any time. But a short-term health plan can deny you for health reasons. The amount of your premium payment might change.
- If you want to sign up for a health plan covered by ACA laws: You can sign up for another plan only during open enrollment or if you have a qualifying life event (like losing coverage from your job or having a baby). To find out if you have a qualifying life event, talk to your insurance agent or go to HealthCare.gov.
    - The next open enrollment dates for ACA plans are:
      2021: November 1 – December 15
      2022: November 1 – December 15
      2023: November 1 – December 15
    - When you sign up for a plan during HealthCare.gov open enrollment dates, your insurance coverage will start January 1.

- The end of this plan is not a qualifying life event. You may have to wait until the next open enrollment period to sign up for an ACA plan.

Am I covered for an injury, illness, or disease I had before I applied for this plan (a preexisting condition)?

No.

- You must tell the truth when answering questions about your health.
- We can deny claims for any injury, illness, or disease you had before signing up for this plan (whether or not you tell us about your condition).

What is the most (maximum) this plan will pay for services?

$ 1 Million per covered person

What is the deductible (the amount that I must pay for services before this plan starts paying)?

You must pay $15,000 per person (per family for Premier Elite plans), per policy term, (plus your premiums) before the plan will start paying for services.

The following covered expenses are exempt from the deductible amount:

- One digital rectal examination and one prostate specific antigen test per policy term, per covered person, for screening for the early detection of prostate cancer.
- Child immunizations, as defined in the certificate.
- One screening test for hearing loss administered within 30 days of birth and related diagnostic follow-up care for 24 months following birth.

Does this plan use a network of doctors/providers?

Yes, the plan is an EPO (exclusive provider benefit plan) and has a network of doctors/providers. Except for emergency care and some other situations, the plan covers care only from in-network providers.

View the plan's list of in-network doctors/providers: Visit UHOne.com and select Find a Doctor to search for network providers in your state.

What type of care will this plan cover?

Review the chart below to know which benefits are covered by this plan. ACA plans cover all listed benefits with few limits, but this plan limits coverage for some types of care.

The chart below does not include your coinsurance amount. Your coinsurance may be found at the beginning of this notice along with your Plan name and deductible amount. All benefits under your plan are subject to the deductible amount and coinsurance unless a copay applies or unless specifically stated otherwise.

Type of Care	Is it covered?
Emergency room visit	Yes, but there are some limits. Additional $500 emergency room deductible ($750 for Value Direct) if not admitted to the hospital for further treatment. Then subject to chosen deductible and coinsurance.
Urgent care	Yes, but there are some limits. Urgent care center charges subject to $50 copay per visit. Exempt from deductible.
Ambulance	Yes, but there are some limits. Air ambulance limited to $5,000 maximum covered expense, per person, per policy term.
Hospital Stay – facility fee (inpatient overnight stay)	Yes, coverage is like ACA plans.
Hospital Stay – doctor services (inpatient overnight stay)	Yes, coverage is like ACA plans.
Day surgery – facility fee (outpatient – no overnight stay)	Yes, coverage is like ACA plans. Covers surgery in doctor's office in addition to hospital and outpatient surgical center.
Day surgery – doctor services (outpatient – no overnight stay)	Yes, coverage is like ACA plans. Covers surgery in doctor's office in addition to hospital and outpatient surgical center.
Mental health services (inpatient – overnight stay)	Yes, coverage is like ACA plans.
Mental health services (outpatient – no overnight stay)	Yes, coverage is like ACA plans.
Alcohol/drug/substance abuse services (inpatient – overnight stay)	Yes, coverage is like ACA plans.
Alcohol/drug/substance abuse services (outpatient – no overnight stay)	Yes, coverage is like ACA plans.

Preventive care (includes regular checkups, and some screenings and vaccines)	No. Regular checkups not covered. State mandated screening and vaccines covered under Medical Benefit.
Primary care (office visit to treat an injury or illness)	Yes, coverage is like ACA plans.
Specialist care office visit (Doctors who treat one type of health issue. Examples: cancer skin issues, allergies, heart issues or kidney issues)	Yes, coverage is like ACA plans.

Drugs ordered by your doctor (outpatient prescription drugs)	Yes, but there are some limits. Coverage is limited to formulary drugs. You can view the formulary and determine the tier status for a prescription drug by accessing your prescription benefits via our website at www.myuhone.com or by calling the telephone number on your identification card. Tier 1 Drugs - $25 Copay Tiers 2-4 Drugs: Subject to deductible and coinsurance. Maximum benefit: $2,500 covered expenses per person.
Services for a pregnant woman: prenatal office visits	No. Covers complications of pregnancy only.
Services for a pregnant woman: delivery – doctor services	No. Covers complications of pregnancy only.
Services for a pregnant woman: delivery – facility fee	No. Covers complications of pregnancy only.

You must confirm you read and understand this form:

Did you read and understand the limited benefits offered by this plan before you applied or paid for coverage?

☑ Yes, I read and understand the benefits and limits of this plan. I was not required to make a payment or apply for this certificate before getting this disclosure form.

Don't sign this document if you don't understand it.

No firme este documento si no lo comprende.

Type or sign your name:

Signature Information	Signature
Proposed Insured (or Parent/Legal Guardian If Proposed Insured is a child)	Kiran Mohan Chitra Raja Mohan Nair
Date	10 05 22

Have a complaint or need help?

To check if an agent has a license or to file a complaint, go to the Texas Department of Insurance's website at www.tdi.texas.gov or call 1-800-252-3439.

Federal notice: This coverage is not required to comply with certain federal market requirements for health insurance, principally those contained in the Affordable Care Act. Be sure to check your certificate carefully to make sure you are aware of any exclusions or limitations regarding coverage of preexisting conditions or health benefits (such as hospitalization, emergency services, maternity care, preventive care, prescription drugs, and mental health and substance use disorder services). Your certificate might also have lifetime and/or annual dollar limits on health benefits. If this coverage expires or you lose eligibility for this coverage, you might have to wait until an open enrollment period to get other health insurance coverage.

CONSENT TO RECEIVE ELECTRONIC RECORDS AND TO CONDUCT TRANSACTIONS ELECTRONICALLY

For the purposes of this form, “Our Transaction” means the entirety of the business relationship between you and us. “Communications” includes, but is not limited to:

1. Your application or enrollment form, including subsequent amendments;
2. Information related to Our Transaction that we are required to provide or make available in writing such as privacy notices or fraud warnings;
3. Documents related to Our Transaction such as policy, certificate, or evidence of coverage forms, claim forms, explanation of benefit forms, premium notices or privacy policies and notices (e.g., HIPAA Notices or Privacy Practices) or other administrative forms (to the extent permitted by applicable law);
4. Any emails, faxes, recorded telephone calls, or other electronic transmissions of information between you and us and an insurance producer contracted with us, or between us and any third party.

Subject to our obligations to protect your privacy, we may, at our sole discretion, post Communications on a website (in which case they will be sent or received, as the case may be, regardless of whether or not we own, operate or control the website). Or send them in or attached to an email. Please be advised that communication by unencrypted email presents a risk of disclosure to, or interception by, unintended third parties. You must promptly tell us about any change to your electronic or physical mailing address, or other contact information.

You acknowledge that you can receive or access Communications because you have the following:

- A telephone
- A computer and printer
- A device or computer program for listening to audio CDs, mp3, WAV or other common computer audio files
- An Internet browser
- Access to the Internet
- A valid email address
- Adobe Acrobat Reader or other sufficient PDF reader

You can request a free copy of any Communications, or withdraw your consent to receive electronic Communications at any time by sending a written request to:

Policy Administration
PO Box 31372
Salt Lake City, UT 84131-0372

☑ I hereby consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. All of the Communications between the time you submit your consent and withdraw your consent will remain valid and binding on both you and us notwithstanding your withdrawal.

☐ I hereby DO NOT consent to receive Communications and Transaction Documents electronically, as per the aforementioned conditions. If you do not consent, we will conduct all future business with you in paper form.

X Kiran Mohan Chitra Raja Mohan Nair (	X
Primary Applicant *(You)*	Parent/Guardian *(if you are a minor)* Relationship
mohankiran06@gmail.com	
Primary Applicant *(You)* Email Address	Parent/Guardian (*if you are a minor*) Email address
10 05 22	096795388
Date	Policy ID Number