

TennHealth Insurance Services

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 TennHealth Insurance Services for review along with the completed application. If you do not have access to a fax machine, send the completed application to TennHealth Insurance Services 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 complete, sign, and date the authorization form.

Don't forget to enclose the initial payment check made payable to:

- "FACT" for all states except CO, CT, DE, GA, KS, KY, LA, NV, NM, SD, and WY
- "Golden Rule" for CO, CT, DE, GA, KS, KY, LA, NV, NM, SD, and WY only

Mail completed applications and check to:

TennHealth Insurance Services

Attn: New Enrollment

210 Hidden Hills Circle

Lexington, TN 38351

TennHealth Insurance Services 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)207-8368 or e-mail us at dlondobson@tennhealth.com.

Norvax form #IN-1

TennHealth Insurance Services

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:**

TennHealth Insurance Services

FAX# (866)306-8009

Dear TennHealth Insurance Services,

Please accept my completed 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 TennHealth Insurance Services at (888)207-8368 to verify receipt of my
application.

****I understand that TennHealth Insurance Services will not review this application until the following
business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original signed application must still be mailed to TennHealth Insurance
Services. I will mail the original signed application to :

TennHealth Insurance Services

Attn: New Enrollment

210 Hidden Hills Circle

Lexington, TN 38351

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

Norvax form #CS-1

FACT MEMBERSHIP ENROLLMENT FORM

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 0105

**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.							
b.							
c.							
d.							
e.							

4. Primary Applicant's Address (P.O. Boxes are not accepted.)

Street (Include Apt.) City State ZIP

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

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

10. Primary Applicant's Mother's Maiden Name: Spouse's Mother's Maiden Name: (Last Name Only) (Last Name Only)

Nov 19 2008 03:56:31 pm

Primary Applicant's initials _____ Spouse's initials _____ Date ____/____/____



COVERAGE INFORMATION

11. Requested Effective Date: ___/___/_____

Special Instructions: _____

All plans include a preferred network.

Network Name: _____

Requested Health Class: Primary: Preferred Standard I Standard II
 Spouse: Preferred Standard I Standard II

Tobacco Use: **Primary** Yes **Spouse** Yes **Child a.** Yes **Child b.** Yes **Child c.** Yes **Child d.** Yes **Child e.** Yes

(See Question 30 for applicants age 18 and older, including dependent children.)

PRODUCT SELECTION & BILLING (or attach health insurance quote)

<input type="checkbox"/> Copay Select SM	FACT Dues	\$	3.00	
<input type="checkbox"/> Copay Saver SM	Base Premium Amount	+	_____	
<input type="checkbox"/> \$ 500 (Copay Select only)	PLAN ENHANCEMENTS — See current brochure and inserts for availability			
<input type="checkbox"/> \$1,000 (Copay Select only)	<input type="checkbox"/> \$5 Million Lifetime Maximum	+	_____	Optional
<input type="checkbox"/> \$1,500 <input type="checkbox"/> \$2,500 <input type="checkbox"/> \$5,000	<input type="checkbox"/> 24 Month Initial Rate Guarantee	+	_____	Optional
<input type="checkbox"/> \$7,500 <input type="checkbox"/> \$10,000	<input type="checkbox"/> No Annual Maximum Prescription Drug	+	_____	Optional
	<input type="checkbox"/> \$25 Office Visit Copay	+	_____	Optional
	<input type="checkbox"/> 2 Additional Dr. Office Visits	+	_____	Optional
	<input type="checkbox"/> Prescription Drug Copay	+	_____	Optional
	OPTIONAL BENEFITS — See current brochure and inserts for availability			
	<input type="checkbox"/> Enhanced Term Life: Primary <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000	+	_____	Optional
	<input type="checkbox"/> Enhanced Term Life: Spouse <input type="checkbox"/> \$50,000 <input type="checkbox"/> \$100,000 <input type="checkbox"/> \$150,000	+	_____	Optional
	<input type="checkbox"/> Accidental Death: Primary	+	_____	Optional
	<input type="checkbox"/> Accidental Death: Spouse	+	_____	Optional
	<input type="checkbox"/> Supplemental Accident: <input type="checkbox"/> \$500 <input type="checkbox"/> \$1,000	+	_____	Optional
	<input type="checkbox"/> Term Life	+	_____	Optional
	<input type="checkbox"/> Maternity Benefit	+	_____	Optional
	<input type="checkbox"/> Preventive Care	+	_____	Optional
	<input type="checkbox"/> UnitedHealthcare Dental: <input type="checkbox"/> Premier SM <input type="checkbox"/> Value SM (if available)	+	_____	Optional
	<input type="checkbox"/> UnitedHealthcare Vision (if available)	+	_____	Optional
	<input type="checkbox"/> HSA Deposit	+	_____	\$25 Monthly Min.
	Total Monthly Payment	= \$	_____	
	One-Time HSA Set-Up Fee	+	_____	\$10
	<input type="checkbox"/> One-Time HSA Indemnity Rider	+	_____	Optional
	Initial Monthly Payment (Make check payable to "FACT")	= \$	_____	
	If Quarterly, Total Monthly Payment x 3	= \$	_____	
	One-Time HSA Set-Up Fee	+	_____	\$10
	<input type="checkbox"/> One-Time HSA Indemnity Rider	+	_____	Optional
	Initial Quarterly Payment (Make check payable to "FACT")	= \$	_____	

12. **Initial Payment With Application** (Premium will be verified and may be adjusted up or down during the underwriting process): Check EFT Credit Card

Ongoing Payments: Monthly EFT (no billing fee) Direct Bill (\$10 monthly billing fee)

Quarterly Direct Bill (\$10 quarterly billing fee)

OTHER COVERAGE

13. Within the last 62 days, has any applicant **been covered by** any type of **medical** insurance? If yes, complete chart below. Yes No
 Your signature on this application indicates your agreement to terminate any existing coverage listed below as being replaced.

Applicant's Name	Company Name	Policy/Certificate Number	Type (Individual, Employer Group, Short Term, COBRA, Medicaid, Other)	Is this to be replaced?	Termination Date

14. Will the term life benefit replace any existing **life** insurance? Company Name _____ Policy # _____ Yes No

15. Has any applicant ever had an application or policy voided, declined, postponed, rated, or charged an extra premium, or had coverage modified (including medical exclusion riders) by any health or life insurer? (If yes, list name and give details.) Yes No
 Person: _____ Company: _____ Action Taken: _____

Date: _____ Reason for Action: _____

16. Has any applicant previously applied for, or been covered by, Golden Rule?
If yes, who? _____ Policy/Certificate # _____

It is a crime to knowingly provide false, incomplete, or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines, and denial of insurance benefits.

DRIVING -- FOR ALL APPLICANTS

17. In the last 24 months, has any applicant participated in driving any type of motorcycle?
If yes, please answer the following questions:
a. Which applicant(s)? Primary Spouse Child a. Child b. Child c. Child d. Child e.
b. Does applicant have a valid motorcycle license? Yes Yes Yes Yes Yes Yes Yes
c. Within the last 24 months, has the applicant had any motor vehicle license suspended or revoked?
d. Within the last 24 months, has the applicant, while operating any 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."

18. Is any family member (whether or not named in this application) pregnant or an expectant mother or father?
19. Do any applicants, other than dependent children, not read, write, speak, and understand the English language?
20. Do you have an adoption pending?
21. In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind?
22. Within the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease or disorder of the:
a. gallbladder?
b. pancreas or liver?
c. joints or spine?
d. kidney?
e. eyes, ears, or nose?
f. mouth, throat, or jaw?
23. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of:
a. high blood pressure?
b. chest pain?
c. headaches?
d. paralysis?
e. arthritis?
f. convulsions or epilepsy?
g. elevated cholesterol?
h. sexually transmitted disease?
i. cancer?
j. diabetes or sugar in the blood or urine?
k. stroke?
l. Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness?
m. tumor, cyst, polyp, lump, or growth of any kind?
n. mental, emotional, or behavioral disorder?
24. In the last 10 years, has any applicant:
a. had a complicated pregnancy or delivery?
b. tested positive for antibodies to the HIV virus?
c. been hospital confined, had surgery, or discussed surgery?
25. In the last 10 years, has any applicant had any indication, signs, symptoms, diagnosis, or treatment of any disease, disorder, or abnormality of the:
a. heart or circulatory system?
b. nervous system?
c. digestive system?
d. muscular or skeletal system?
e. respiratory system?
f. male or female reproductive system, including infertility?
g. urinary system?
h. thyroid, breast, or other glands?
26. 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? ...
27. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more?
28. 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?
29. Is any applicant currently, or in the last 5 years been, a user of alcoholic beverages in excess of 14 drinks per week?
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).
30. 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 11.)
31. 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.

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 health 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.

By signing below, I certify that I understand that I am applying for personal health insurance that may never be used as employer-provided insurance.

002C-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 employer, insurance company, government agency,

consumer-reporting agency, or the 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 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: Health Insurance Certification and Authorization to Obtain and Disclose Nonmedical Information.

Signed X _____ at _____
Date City State

X _____
Signature of Parent/Guardian (If you are a minor)

X _____
Signature of Primary Applicant (You)

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, consumer-reporting agency, 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 (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 as described 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 regulating health insurers.

I have retained a copy of this authorization.

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

Signed X _____ at _____
Date City State

X _____
Signature of Parent/Guardian (If you are a minor)

X _____
Signature of Primary Applicant (You)

X _____
Signature of Spouse (If to be covered)

**This form must be signed and returned to GOLDEN RULE INSURANCE COMPANY with all applications.
TENNESSEE PORTABILITY CERTIFICATION**

INSTRUCTIONS (You may be eligible for a portability plan — guarantee issue without preexisting conditions limits.)

PART I Review the statements and sign where appropriate.

PART II, PART III, PART IV Review and complete only if you sign under B. in Part I.

PART I ELIGIBILITY INFORMATION (Decide whether or not all of the statements 1-6 apply to you.)

1. I do not have any other health insurance coverage (or it will be involuntarily terminated soon).
2. I have been insured by *creditable coverage*¹ (as defined below) for the last 18 months or more with no lapse in coverage of more than 63 days.
3. My most recent coverage was under a *group health plan*² (as defined below), a governmental plan, or a church plan.
4. My most recent coverage was not terminated due to nonpayment of premiums, fraud, or intentional misrepresentations.
5. I am not eligible for any coverage under a *group health plan*² (as defined below), Medicare, or Medicaid.
6. I accepted and exhausted any group continuation of coverage (including COBRA) that was offered to me — or — I was not offered group continuation of coverage (including COBRA).

Carefully review the statements above and sign below where appropriate.

A. One or more of the six statements above **do not** apply to me.

Signature _____ Date _____

If you signed under A, STOP here.

— OR —

B. I represent that all six of the statements above **do** apply to me.

Signature _____ Date _____

If you signed under B, answer the questions below and complete the rest of this form.

How many employees work for the employer that most recently provided your health insurance?

Were you eligible for COBRA or group continuation of coverage? YES NO

If yes, did you maintain COBRA or group continuation until it expired? YES NO

PART II PLAN DESIGN, PRICE, AND AVAILABILITY (HSA 100[®], Preferred Network, \$3,500/\$7,000 deductible with no annual maximum on prescription drug or Copay SelectSM, Preferred Network, \$2,500 deductible with no annual maximum on prescription drug.)

How does portability affect plan design?

Portability plans: 1) do not include a 12-month rate guarantee; 2) do not apply preexisting conditions limitations; 3) do not offer the optional benefits typically available with the plan; and 4) have higher premium rates.

What happens if a family applies and not all are eligible for portability?

Those who are eligible will be considered for a portability plan, and those not eligible will be subject to underwriting for a plan without portability rights.

How are premiums calculated?

Initial rates are higher for portability plans. Rates may increase substantially (up to 200%) after underwriting — see To Calculate Payment.

What if only one or two family members want to apply for a portability plan and the others want to be underwritten for a plan without portability rights?

Complete two separate applications, and we will consider the family members under two separate plans. Children are not required to apply with their parent, but may apply separately.

To Calculate Payment:

Total Monthly Payment _____
(Rate from your Insurance Representative)

Preexisting Waiver Factor x 1.10

Monthly **Minimum** Total = _____
..... x 2.00

Monthly **Maximum** Total = _____

¹*Creditable coverage* includes group or individual health insurance coverage, Medicare, Medicaid, Armed Forces coverage, Indian or tribal coverage, state risk pool coverage, public health coverage, and Peace Corps Act coverage. A plan is NOT creditable coverage if it: a) provides coverage only for accidents, disability, or liability; b) is credit-only insurance; or c) is secondary to other insurance.

²Generally, a *group health plan* is any coverage existing in connection with employment. Included are: employer-sponsored plans (so long as at least one employee participates); coverage of an employee under an individual policy of insurance that is part of a plan, fund, or program established or maintained by an employer that provides medical care to employees or their dependents; coverage of a business owner so long as at least one employee other than the business owner and the business owner's spouse also participates in the plan; and coverage of partners in a plan maintained by the partnership.

PART III APPLICATION (You must sign and date in ONE of the boxes below if you signed under B. in Part I.)**Applying for a Portability Plan (guaranteed-issue coverage)**

I signed under B. in Part I because all six statements under Part I apply to me. While I understand that Golden Rule makes the final determination regarding eligibility, I am applying for a portability plan. My signature below confirms that my portability rights were explained and the minimum and maximum rates were made available to me.

X _____
Signature of Proposed Insured

X _____
Date

Not Applying for a Portability Plan (guaranteed-issue coverage)

Even though I believe I am eligible for a portability plan, I am not applying for a portability plan. My signature below confirms that my portability rights were explained; portability coverage was offered; the minimum and maximum rates were made available, and I do not wish to pursue this option at this time.

I realize if I am eligible and I do not apply for a portability plan within 62 days of losing my group coverage, this right may no longer be available to me.

X _____
Signature of Proposed Insured

X _____
Date

PART IV PROOF OF CREDITABLE COVERAGE (Complete only if you are applying for a portability plan.)**Option 1****OR****Option 2**

- 1) Provide the information requested below; and
- 2) Provide copies of "certificates of creditable coverage" as evidence of coverage under each health plan for the past 18 months. *Certificates of creditable coverage* are available from your prior health insurance administrators.

- 1) Provide the information requested below; and
- 2) Provide copies of "supporting documents" as evidence of coverage under each health plan for the past 18 months. *Supporting documents* may include copies of the following: identification card, explanation of benefits, pay stubs showing a deduction for health coverage, insurance certificate, and/or cancelled premium payment checks.

Details About Your Most Recent Coverage

Most Recent Employer Name and Address		Employment Termination Date		Phone No.	
Most Recent Insurance Company Name and Address		Effective Date	Termination Date	ID No.	Phone No.
Other Insurance Companies for the Past 18 Months		Effective Date	Termination Date	ID No.	Phone No.