

Please mail the completed application to:

MTN Health Insurance, LLC
PO Box 399
Eastlake, CO 80614

Questions? Call 303-594-1939

**APPLICATION FOR SHORT TERM MEDICALSM INSURANCE
GOLDEN RULE INSURANCE COMPANY – LAWRENCEVILLE, ILLINOIS 62439**

Please Print
in Blue Ink.

No application will be accepted if received by Golden Rule at its Lawrenceville or Indianapolis Office more than 15 days after the date signed.

Yes No

Have you or any other person to be insured been covered under two or more nonrenewable short-term policies during the past twelve months? ..
If "Yes," then this policy cannot be issued. You must wait six months from the date of your last such policy to apply for a short-term policy.

This policy does not provide portability of prior coverage. As a result, any injury, sickness, or pregnancy for which you have incurred charges, received medical treatment, consulted a health care professional, or taken prescription drugs within twelve months of the effective date of this policy will not be covered under this policy.

PROPOSED INSURED

Male
 Female
Sex

_____/_____/_____ _____ _____ _____/_____/_____ _____ _____

First Middle Initial Last Birth Date Age Sex

RESIDENT ADDRESS (P.O. Boxes are not accepted.)

_____/_____/_____ _____ _____ _____ _____ _____

Street (Include Apt.) City State ZIP Telephone No.

1. List below any dependents to be covered under the policy.

Dependent's First Name	Relationship to You	Date of Birth*	Dependent's First Name	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.

2. Are you or is any family member (whether or not named in this application) an expectant mother or father? Yes No
If yes, coverage cannot be issued.....
3. Have you or has 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.)
4. Have you or has 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.)
5. Do you or does 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.)
6. Within the last 5 years, have you or has 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.)

DEDUCTIBLE: \$ 250 \$ 500 \$1,000 \$1,500 \$2,500 **REQUESTED EFFECTIVE DATE:** ____/____/____
(See Statement of Understanding section on the next page.)

MONTHS OF COVERAGE: 1 MO. 2 MO. 3 MO. 4 MO. 5 MO. 6 MO.

Important Note:
"Postmark date" means the date of the postmark as affixed by the U.S. Postal Service.



ALTERED APPLICATIONS WILL NOT BE ACCEPTED.

You normally do not require more than one policy. If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.

You may be eligible for benefits under Medicaid or Medicare and may not need an accident and sickness policy. If you are eligible for Medicare, you may want to purchase a Medicare Supplement policy. If you are eligible for Medicare due to age or disability, counseling services may be available in your state to provide advice concerning your purchase of Medicare supplement insurance and concerning medical assistance through the state Medicaid program.

"It is unlawful to knowingly provide false, incomplete, or misleading facts or information to an insurance company for the purpose of defrauding or attempting to defraud the company. Penalties may include imprisonment, fines, denial of insurance, and civil damages. Any insurance company or agent of an insurance company who knowingly provides false, incomplete, or misleading facts or information to a policyholder or claimant for the purpose of defrauding or attempting to defraud the policyholder or claimant with regard to a settlement or award payable from insurance proceeds shall be reported to the Colorado division of insurance within the department of regulatory agencies."

To the best of your knowledge:

	Yes	No
7. Do you have another insurance policy or contract in force?	<input type="checkbox"/>	<input type="checkbox"/>
(a) If so, with which company? _____		
(b) If so, do you intend to replace your current accident and sickness insurance with this policy?	<input type="checkbox"/>	<input type="checkbox"/>
8. Do you have any other accident and sickness insurance that provides benefits similar to this accident and sickness policy?	<input type="checkbox"/>	<input type="checkbox"/>
(a) If so, with which company? _____		
(b) What kind of policy? _____		
9. Are you covered for medical assistance through the state Medicaid program?	<input type="checkbox"/>	<input type="checkbox"/>
(a) As a Specified Low Income Medicare Beneficiary (SLMB)?	<input type="checkbox"/>	<input type="checkbox"/>
(b) As a Qualified Medicare Beneficiary (QMB)?	<input type="checkbox"/>	<input type="checkbox"/>
(c) For other Medicaid medical benefits?	<input type="checkbox"/>	<input type="checkbox"/>

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 avoidance 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 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.

<u>X</u>	<u>X</u>	<u>X</u>
Proposed Insured's Signature or Parent/Legal Guardian if proposed insured is a child	State where you signed this application	Date you signed and read application

BROKER CERTIFICATION

1. List any other health insurance policies/certificates personally sold to the applicant which are still in force. Indicate if policy/certificate to be replaced.

Name of Company	Type of Coverage	To Be Replaced

2. List any policy/certificate personally sold to the applicant within the past five (5) years which is no longer in force.

Name of Company	Type of Coverage	Policy/Certificate Number

Don Osborn	
Licensed Agent or Broker (Please Print.)	Individual Producer #

Payment Options: *Must choose one*

Single Payment: Check or money order \$ Amt. _____ (Total Single Payment on reverse. Includes \$20 nonrefundable application fee.)
For this method of payment, you must make check or money order payable to Golden Rule. (EFT also available with online application)

OR

Single Payment: Credit card \$ Amt. _____ (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 Golden Rule Insurance Company to bill my Visa/MasterCard account for the total payment.

Account No. _____ Expiration Date _____/_____/_____
Name on Credit Card _____ X _____ Phone No. _____
Signature of Authorized User
Billing Address _____ City _____ State _____ ZIP _____

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

OR

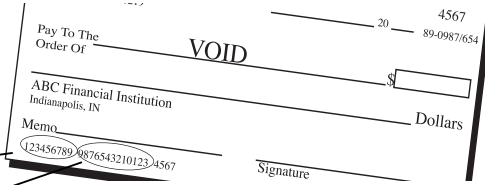
Monthly Payment: Electronic Funds Transfer (EFT) \$ Amt. _____ (Total Initial Payment on reverse. First month amount (shown) includes a one-time \$20 nonrefundable application fee.) Additional monthly EFT payments will be \$20 less. For this method of payment, you must complete the EFT Authorization below.

Electronic Funds Transfer (EFT) Authorization

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 of its termination from me.

Nine-digit Check Routing No. _____ Checking Account No. _____
Financial Institution Name _____ Address _____
City _____ State _____ ZIP _____
Draft On _____ Day _____ X _____
Account Holder's Signature _____ 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.

Account Holder's E-mail Address _____

NOTICE TO APPLICANT REGARDING REPLACEMENT OF ACCIDENT AND SICKNESS INSURANCE

GOLDEN RULE INSURANCE COMPANY: 712 Eleventh Street • Lawrenceville, IL 62439

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

According to your application, you intend to lapse or otherwise terminate your present policy and replace it with a policy to be issued by Golden Rule Insurance Company. Your new policy will provide ten (10) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that purchase of this accident and sickness coverage is a wise decision, you should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER OR BROKER:

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this accident and sickness policy will not duplicate your existing coverage because you intend to terminate your existing coverage. The replacement policy is being purchased for the following reason(s) (check one):

- Additional benefits.
- No change in benefits, but lower premiums.
- Fewer benefits and lower premiums.
- Other (please specify) _____

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 may have been payable under your present policy.

2. If 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 and 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, review it carefully to be certain that all information has been properly recorded.

Do not cancel your present policy until you have received your new policy and are sure that you want to keep it.

Signature of Broker

Don Osborn

Typed Name of Broker

PO Box 399 Eastlake, CO 80614

Address of Broker

Applicant's Signature

Date

Golden Rule's Copy

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Signature of Broker

Don Osborn

Typed Name of Broker

PO Box 399 Eastlake, CO 80614

Address of Broker

Applicant's Signature

Date

Applicant's Copy

Jul 29 2008 10:04:08 am

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