

APPLICATION FOR DENTAL/VISION INSURANCE
GOLDEN RULE INSURANCE COMPANY — INDIANAPOLIS, INDIANA

PLEASE PRINT IN BLUE INK

APPLICANT(S) INFORMATION

PROPOSED INSURED:

First Name

Middle Initial

Last Name

Birth Date:

Month

Day

Year

Age

Gender

Male

Female

Mailing Address:

Street (Include Apt.)

City

State

ZIP

A physical address is required if different than your mailing address. P.O. Boxes are not accepted as a physical address.

Physical Address:

Street (Include Apt.)

City

State

ZIP

Phone Numbers:

() Home

() Other

Best number and times to call

E-mail Address

DEPENDENTS: List below any dependents to be covered under the policy.

Name (Last, First, M.I.)

Relationship

Birth Date

Gender

Table rows for dependent names

Table rows for dependent relationships

Table rows for dependent birth dates

Table rows for dependent genders

PAYOR:

(If not You):

Name

E-mail Address

Street

Street

City

State

ZIP

- 1. Total Annual Household Income: \$15,000 or less, \$15,001 to \$35,000, \$35,001 to \$50,000, \$50,001 to \$75,000, \$75,001 to \$99,999, \$100,000 or more

- 2. Have you or has any applicant lived in the 50 states of the USA or the District of Columbia for less than the past 12 months?
3. Do you or does any applicant now have dental insurance that will not terminate prior to the requested effective date?
4. If you are applying for vision insurance, do you or does any applicant now have vision insurance that will not terminate prior to the requested effective date?



REQUESTED EFFECTIVE DATE: ____/____/____

(See Statement of Understanding section.)

Plan Choices: UnitedHealthcare Dental PremierSM UnitedHealthcare Dental ValueSM (if available)

OPTIONAL: UnitedHealthcare Vision (if available)

Payment Mode: Monthly Quarterly Semi-annual Annual

Payment Options: Initial Payment with Application: Check EFT Credit Card

Ongoing Payments: Monthly EFT Direct Bill

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 with this application; (b) if other dental/vision insurance exists that duplicates coverage under the dental/vision plan being applied for, the existing dental/vision coverage must be terminated prior to the effective date of this coverage; (c) if coverage is issued, the coverage will not be a continuation of any prior coverage; and (d) the policy being applied for may contain waiting periods for certain benefits listed on the policy Data Page. 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 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. 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 _____ X _____ X _____
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
X _____ X _____
Licensed Agent or Broker (Please print.) Individual Producer Number

BROKER STATEMENT: Review the completed application before signing below.

I verify that each question on the application was completed by the applicant(s). The applicant has received a Notice of Information Practices. I am not aware of any information that conflicts with the answers provided in this application.

X _____
Signature of Licensed Broker

Broker E-mail Address

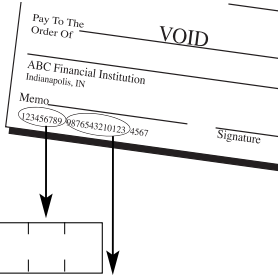
IMPORTANT NOTES: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service. No application will be accepted if received by Golden Rule more than 15 days after the date signed. Altered applications will not be accepted.

CONTINUE WITH PAYMENT INFORMATION ON NEXT PAGE

Mail completed application to:
Golden Rule Insurance Company
DENTAL APPLICATION
PO Box 68994
Indianapolis, IN 46268-0994

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

I (we) hereby authorize 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.



Financial Institution's Name _____
 Address _____
 City, State, ZIP _____
 Draft On _____ Day _____ Date Signed _____

Type of Account: Checking Savings

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.

Nine-digit Routing No. _____

X _____
 Authorized Account Signature

Acct No. _____

E-mail Address _____

INITIAL PAYMENT CREDIT CARD AUTHORIZATION

I authorize Golden Rule to bill my MasterCard/Visa account for the Total Premium for Mode Chosen.*

Card Number: _____

Type of Card: MasterCard Visa Exp. Date: _____
 Month Year

X _____
 Signature of Authorized User

Name as Printed on Card: _____

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

Billing Address _____ City _____ State _____ ZIP _____

CALCULATE YOUR PREMIUM

1 MICHIGAN DENTAL BASE RATES

UnitedHealthcare Dental Premier Statewide	1 Person	2 People	3+ People
	33.66	66.65	117.81
UnitedHealthcare Dental Value ZIP Codes 480-485	20.11	39.82	70.39

2 TREND FACTORS

Effective Dates	Factor
January through March 2009	1.015
April through June 2009	1.030
July through September 2009	1.045
October through December 2009	1.060

3 MICHIGAN VISION RATES

Statewide	9.00	16.00	24.00
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4 PAYMENT MODE FACTORS

Modes	Factor
Monthly	1
Quarterly	3
Semi-annual	6
Annual	12

PREMIUM CALCULATION	
1 Dental Base Rate for Plan Chosen	_____
2 Trend Factor	x _____
3 Subtotal	= _____
4 Vision Rate	+ _____
5 Subtotal	= _____
6 Payment Mode Factor	x _____
Premium for Mode Chosen*	= _____

*The amount charged to your credit card will be the total amount for the payment mode chosen (Monthly, Quarterly, Semi-annual, or Annual).