APPLICATION FOR DENTAL 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.)	Birth Date
☐ Male ☐ Female	Primary(You) (must be age 64 or older)	
☐ Male ☐ Female	Spouse/Registered Domestic Partner	
☐ Male ☐ Female	Child 1	
☐ Male ☐ Female	Child 2	
☐ Male ☐ Female	Child 3	
☐ Male ☐ Female	Child 4	
☐ Male ☐ Female	Child 5	
☐ Male ☐ Female	Child 6	

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

Street (Include Apt.)	City	State	ZIP Code

Mailing Address (if different than Resident Address)

Street (Include Apt.)	City	State	ZIP Code

Explain why the mailing address is different than the resident physical address: _____

_____

Payor (if not you)

Name (Last, First, M.I.):			
Street (Include Apt.)	City	State	ZIP Code

CALIFORNIA LAW PROHIBITS AN HIV TEST FROM BEING REQUIRED OR USED BY HEALTH INSURANCE COMPANIES AS A CONDITION OF OBTAINING HEALTH INSURANCE COVERAGE.

Contact Information

	Phone Number	Email
Primary (You)		
Spouse/Registered Domestic Partner		
Dependent Child age 18 and over		
Dependent Child age 18 and over		
Payor (if not you)		

Your Beneficiary:_____You will be the beneficiary for your spouse/registered domestic partner.

Name Relationship Date of Birth

Plan Selection

Requested Effective Date: ____/____/_____ *(See Statement of Understanding section)*

Plans *(Choose One)*	☐ Gen Saver ☐ Gen Plus ☐ Gen Basic ☐ Gen Deluxe
Optional	☐ Vision

Initial Payment

Estimated Monthly Premium $ _____

Initial Monthly Payment with Application $ _____

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ARBITRATION AGREEMENT

All persons to be covered have read and understand the Arbitration Agreement on this application. A reproduction of this acknowledgement shall be as valid as the original.

ALL PERSONS TO BE INSURED AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS AS TO WHETHER ANY MEDICAL SERVICE RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPLETELY RENDERED), BETWEEN ALL PERSONS TO BE ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND GOLDEN RULE INSURANCE COMPANY OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT AND CALIFORNIA CODE OF CIVIL PROCEDURES §1281 AND §1294 ET SEQ PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION. ARBITRATION HEARINGS WILL BE HELD IN ORANGE COUNTY CALIFORNIA, OR AT A LOCATION AGREED TO IN WRITING BY
ME AND GOLDEN RULE INSURANCE COMPANY. THE EXPENSES OF THE ARBITRATION WILL BE PAID BY GOLDEN RULE INSURANCE COMPANY.

Primary Applicant's Signature X_____ Date_____
(Signature of primary applicant, authorized representative, or if child only and not legal age, signature of parent or legal guardian).

Spouse's/Registered Domestic Partner's Signature X_____ Date_____
(If spouse/domestic partner is to be covered)

Dependent's Signature (age 18 or older) X_____ Date_____
(If Dependents are to be covered) X_____ Date_____

ALL PERSONS TO BE COVERED AGREE TO THE ABOVE ARBITRATION AGREEMENT.

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Statement of Understanding

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

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

(2) If other dental/vision insurance exists that duplicates coverage under the dental/vision plan being applied for, existing dental/vision coverage must be terminated prior to the effective date of this coverage.

(3) The primary applicant must be age 64 or older to be eligible for coverage.

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

(5) The information provided in this application may result in claim denial or voidance of coverage if it constitutes fraud or intentional misrepresentation of material fact. However, there may be no cancellation, limitation of policy provisions, or premium increases due to inaccuracies in the application form, whether willful or not, after 24 months following issuance of the policy.

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

(7) An application, if approved, will be effective the later of:
   (a) The requested effective date; or
   (b) The day after receipt by GRIC or if mailed, the day after the postmark date.

(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 GRIC rejects this application, under no circumstances will any benefits be payable. Receipt of payment by GRIC does not constitute approval of my application or create GRIC coverage.

(10) I have received a Notice of Privacy Practices and a Conditional Receipt or Conditions Prior to Coverage.

(11) For any applicant who is eligible for Medicare, I acknowledge that applicant has access to/has received a Guide to Health Insurance for People with Medicare. The Guide to Health Insurance for People with Medicare is available at: https://www.medicare.gov/Pubs/pdf/02110-Medicare-Medigap.guide.pdf.

(12) THIS IS NOT A MEDICARE SUPPLEMENT POLICY.

(13) The policy being applied for may contain waiting periods for certain benefits listed on the policy Data Page.

Signature Information

	Signature	Date Signed
Primary Applicant (or Parent/Legal Guardian if Primary Applicant is a minor)		

CALIFORNIA ATTESTATION FORM

1. To the best of my knowledge, the information on the application is complete and accurate.
2. I have explained to the applicant, in easy-to-understand language, the risk to the applicant of providing inaccurate information and attest that the applicant understood the explanation.
3. I understand that if I willfully state as true any material fact I know to be false, in addition to any applicable penalties or remedies available under current law, I may be subject to a civil penalty of up to $10,000.

X _____ X _____

Signature of Agent/Broker (required) Date

X Sofia Baghaeimehr X _____

Type or Print Agent/Broker Name Individual Producer Number

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IMPORTANT NOTICE TO PERSONS ON MEDICARE
THIS INSURANCE DUPLICATES SOME MEDICARE BENEFITS

This is not Medicare Supplement Insurance

This insurance provides limited benefits, if you meet the policy conditions, for expenses relating to the specific services listed in the policy. It does not pay your Medicare deductibles or coinsurance and is not a substitute for Medicare Supplement insurance.

This insurance duplicates Medicare benefits when:

- Any of the services covered by the policy are also covered by Medicare

Medicare pays extensive benefits for medically necessary services regardless of the reason you need them. These include:

- Hospitalization
- Physician services
- Outpatient prescription drugs if you are enrolled in Medicare Part D
- Other approved items and services

Before You Buy This Insurance

√ Check the coverage in **all** health insurance policies you already have.
√ For more information about Medicare and Medicare Supplement insurance, review the *Guide to Health Insurance for People with Medicare,* available from the insurance company.
√ For help in understanding your health insurance, contact your state insurance department or state health insurance assistance program (SHIP).

45574-X-0918

Payment

Payment Method – Select One Below

☐ EFT – Complete EFT Authorization below

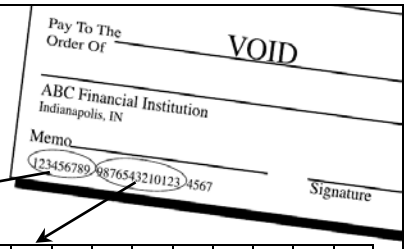
☐ Credit Card – Complete Credit Card Authorization below

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.

☐ ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION – ONLY IF PAYING BY EFT:

I (we) hereby authorize 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 my 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 – ONLY IF PAYING BY CREDIT CARD:

I authorize Golden Rule Insurance Company to bill my American Express/MasterCard/Visa account.

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

Billing ZIP Code: _____ Card Number. _____

X _____
Signature of Authorized Signature

Charge On _____
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.

California Nondiscrimination Notice and Access to Communication Services

Golden Rule Insurance Company does not exclude, deny covered health care benefits to or otherwise discriminate against any member on the ground of race, color, national origin, ancestry, religion, sex, marital status, gender, gender identity, sexual orientation, age, or disability for participation in or receipt of the covered health care services under any of its health plans, whether carried out by Golden Rule Insurance Company directly or through a Network Medical Group or any other entity with which Golden Rule Insurance Company arranges to carry out covered health care services under any of its health plans.

Free services are available to help you communicate with us. Such as letters in other languages or in other formats like large print. Or you can ask for an interpreter at no charge. To ask for help, please call the toll-free number (800) 657-8205. TTY 711

If you think you weren't treated fairly because of your sex, age, race, color, national origin, or disability, you can send a complaint to:

Grievance Administrator
PO Box 31371
Salt Lake City UT 84131-0371
Fax: 801-478-5463
Phone: 800-657-8205
uhoappealsandgrievances@uhc.com

You must send the complaint within 60 days of when you found out about it. A decision will be sent to you within 30 days. If you disagree with the decision, you have 15 days to ask us to look at it again. If you need help with your complaint, please call the toll-free number listed on your health plan ID card.

You can also file a complaint with the U.S. Dept. of Health and Human Services.

Online: https://ocrportal.hhs.gov/ocr/portal/lobby.jsf
Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.
Phone: Toll-free 1-800-368-1019, 800-537-7697 (TDD)
Mail: U.S. Dept. of Health and Human Services
200 Independence Avenue, SW Room 509F, HHH Building
Washington, D.C. 20201

45642-G-1118

California Language Assistance Notice

English

IMPORTANT LANGUAGE INFORMATION:

You may be entitled to the rights and services below. You can get an interpreter or translation services at no charge. Written information may also be available in some languages at no charge. To get help in your language, please call your health plan at: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Spanish

INFORMACIÓN IMPORTANTE DEL LENGUAJE:

Puede tener derecho a los derechos y servicios a continuación. Puede obtener un intérprete o servicios de traducción sin cargo. La información por escrito también puede estar disponible en algunos idiomas sin cargo. Para obtener ayuda en su idioma, llame a su plan de salud al: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Chinese

重要語言信息：

您可能有權享受以下權利和服務。 您可以免費獲得口譯或翻譯服務。 書面信息也可能以某些語言免費提供。 如需獲得您的語言幫助，請致電您的健康計劃：Golden Rule Insurance Company 1-800-657-8205 / TTY：711.

Arabic

معلومات مهمة عن اللغة:

قد يحق لك الحصول على الحقوق والخدمات أدناه. يمكنك الحصول على ترجمة شفوية دون مقابل. قد تكون المعلومات المكتوبة متاحة أيضاً في بعض اللغات دون مقابل. للحصول على المساعدة بلغتك ، يرجى الاتصال بخطة الرعاية الصحية الخاصة بك على العنوان التالي: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711

Armenian

ԿԱՐԵՎՈՐ ԼԵԶՎԻ ՏԵՂԵԿՈՒԹՅՈՒՆՆԵՐ.

Դուք կարող եք իրավասվել ստորեւ նշված իրավունքներին եւ ծառայություններին: Դուք կարող եք անվճար թարգմանիչ կամ թարգմանչական ծառայություններ ստանալ: Գրավոր տեղեկությունները կարող են մատչելի լինել նաեւ որոշ լեզուներով անվճար: Ձեր լեզվով օգնություն ստանալու համար խնդրում ենք զանգահարել ձեր առողջապահական ծրագիրը `Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Cambodian

ព័ត៌មានជាភាសាសំខាន់:

អ្នកអាចមានសិទ្ធិទទួលបានសិទ្ធិនិងសេវាកម្មដូចខាងក្រោម។

អ្នកអាចទទួលបានអ្នកបកប្រែឬអ្នកបកប្រែភាសាដោយឥតគិតថ្លៃ។

ព័ត៌មានដែលអាចសរសេរបានអាចមានជាភាសាមួយចំនួនដោយមិនគិតថ្លៃ។

ដើម្បីទទួលបានជំនួយជាភាសារបស់អ្នកសូមទូរស័ព្ទទៅផែនការសុខភាពរបស់អ្នកនៅ: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

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Farsi

اطلاعات مهم در مورد زبان:

شما ممکن است به حقوق و خدمات زیر توجه داشته باشید. شما می توانید مترجم یا خدمات ترجمه را بدون هزینه دریافت کنید. اطلاعات نوشته شده ممکن است در بعضی از زبانها بدون پرداخت هزینه باشد. برای دریافت کمک به زبان خود، لطفا با برنامه بهداشتی خود تماس بگیرید:

Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Hindi

महत्वपूर्ण भाषा जानकारी:

आप नीचे अधिकार और सेवाओं के हकदार हो सकते हैं। आप बिना किसी शुल्क के एक दुभाषिया या अनुवाद सेवाएं प्राप्त कर सकते हैं। बिना किसी शुल्क के लिखित जानकारी कुछ भाषाओं में भी उपलब्ध हो सकती है। अपनी भाषा में सहायता प्राप्त करने के लिए, कृपया अपनी स्वास्थ्य योजना यहां कॉल करें: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Hmong

COV LUS LUS TSEEM CEEB:

Koj tuaj yeem tsim nyog tau cov cai thiab cov kev pab hauv qab no. Koj tuaj yeem tau txais neeg txhais lus los yog txhais lus pab dawb tsis them nyiaj. Cov ntaub ntawv sau kuj muaj nyob rau qee hom lus dawb xwb. Xav tau kev pabcuam ntawm koj hom lus, thov hu rau koj qhov kev npaj khomob ntawm: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Japanese

重要な言語情報：

あなたは以下の権利とサービスを受ける権利があります。 通訳や翻訳サービスを無料で受けることができます。 書かれた情報は、一部の言語で無償で入手できる場合もあります。 あなたの言語で助けを得るためには、あなたの健康計画に電話してください：Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Korean

중요한 **언어 정보 :**

귀하는 아래 권리와 서비스를받을 자격이 있습니다. 통역사 또는 번역 서비스를 무료로 받으실 수 있습니다. 서면 **정보**는 일부 **언어**로 무료로 제공 될 수도 있습니다. 귀하의 **언어**로 도움을 받으려면 다음의 건강 플랜에 전화하십시오. Golden Rule Insurance Company 1-800-657-8205 / TTY: 711..

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Punjabi

ਮਹੱਤਵਪੂਰਨ ਭਾਸ਼ਾ ਜਾਣਕਾਰੀ:

ਤੁਸੀਂ ਹੇਠਾਂ ਦਿੱਤੇ ਅਧਿਕਾਰ ਅਤੇ ਸੇਵਾਵਾਂ ਦੇ ਹੱਕਦਾਰ ਹੋ ਸਕਦੇ ਹੋ ਤੁਸੀਂ ਬਿਨਾ ਕਿਸੇ ਲਾਗਤ 'ਤੇ ਦੁਭਾਸ਼ੀਆ ਜਾਂ ਅਨੁਵਾਦ ਸੇਵਾਵਾਂ ਪ੍ਰਾਪਤ ਕਰ ਸਕਦੇ ਹੋ. ਲਿਖਤੀ ਜਾਣਕਾਰੀ ਕੁਝ ਭਾਗੀਦਾਰਾਂ 'ਤੇ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ' ਤੇ ਵੀ ਉਪਲਬਧ ਹੋ ਸਕਦੀ ਹੈ. ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਪ੍ਰਾਪਤ ਕਰਨ ਲਈ, ਕਿਰਪਾ ਕਰਕੇ ਆਪਣੀ ਸਿਹਤ ਯੋਜਨਾ ਨੂੰ ਇੱਥੇ ਕਾਲ ਕਰੋ: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711

Russian

ВАЖНАЯ ИНФОРМАЦИЯ ЯЗЫКА:

Вы можете иметь право на права и услуги, указанные ниже. Вы можете бесплатно получить переводчика или услуги переводчика. Письменная информация также может быть доступна на некоторых языках бесплатно. Чтобы получить помощь на своем языке, позвоните в свой план медицинского обслуживания по адресу: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711

Tagalog

IMPORMASYONG IMPORMASYON SA LANGUAGE:

Maaaring may karapatan ka sa mga karapatan at serbisyo sa ibaba. Maaari kang makakuha ng isang interpreter o mga serbisyo ng pagsasalin nang walang bayad. Ang nakasulat na impormasyon ay maaari ding makuha sa ilang mga wika nang walang bayad. Upang makakuha ng tulong sa iyong wika, mangyaring tawagan ang iyong planong pangkalusugan sa: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711.

Thai

ข้อมูลภาษาสำคัญ:

คุณอาจได้รับสิทธิ์และบริการด้านล่าง คุณสามารถขอรับบริการล่ามหรือแปลภาษาโดยไม่มีค่าใช้จ่าย ข้อมูลที่เป็นลายลักษณ์อักษรอาจมีให้บริการในบางภาษาโดยไม่มีค่าใช้จ่าย หากต้องการความช่วยเหลือในภาษาของคุณโปรดติดต่อแผนประกันสุขภาพของคุณได้ที่: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711

Vietnamese

THÔNG TIN NGÔN NGỮ QUAN TRỌNG:

Bạn có thể được hưởng các quyền và dịch vụ dưới đây. Quý vị có thể nhận dịch vụ phiên dịch hoặc dịch thuật miễn phí. Thông tin bằng văn bản cũng có thể có sẵn bằng một số ngôn ngữ miễn phí. Để nhận trợ giúp bằng ngôn ngữ của bạn, vui lòng gọi cho chương trình sức khỏe của bạn tại: Golden Rule Insurance Company 1-800-657-8205 / TTY: 711

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CONSENT TO RECEIVE ELECTRONIC RECORDS AND TO CONDUCT TRANSACTIONS ELECTRONICALLY

By submitting this consent form or a health insurance application or HMO enrollment form, you hereby consent to presentation, delivery, storage retrieval and transmission of "Communications" related to "Our Transaction" as electronic records instead of in paper form.

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 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 _____
Primary Applicant *(You)*

X _____
Parent/Guardian *(if you are a minor)* Relationship

_____
Primary Applicant *(You)* Email Address

X _____
Parent/Guardian *(if you are a minor)* Email Address

_____
Date

_____
Policy ID Number