GOLDEN RULE INSURANCE COMPANY
APPLICATION FOR INSURANCE

MUST BE COMPLETED BY THE APPLICANT(S) **PLEASE PRINT IN BLACK INK**

APPLICANT(S) INFORMATION

1. **REASON FOR APPLICATION:** ❑ New Application ❑ Add a dependent ID Number
❑ Reinstatement ❑ Change deductible
(for additions, reinstatements, or deductible changes)

2. **PRIMARY APPLICANT'S INFORMATION:**

a. Name (Last, First, M.I.): _____

b. Mailing Address
Street (Include Apt.)
City State ZIP

c. **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

d. Phone Numbers: (_____) _____ (_____) _____
Home Other Best number and times to call Email Address

e. Payor: _____
(If not You): Name Email Address
Street City State ZIP

f. Your Beneficiary: _____ You will be the beneficiary for your spouse.
Name Relationship Age

g. Your Occupation: _____ h. Marital Status: ❑ Married ❑ Single

3. **APPLICANTS FOR COVERAGE:** Please list only those persons needing coverage.

Gender	Name (Last, First, M.I.)	Birth Date	Age	MUST BE ACCURATE Height	Weight
❑ Male ❑ Female	a. Primary (You)				
❑ Male ❑ Female	b. Spouse				
❑ Male ❑ Female	c. Child				
❑ Male ❑ Female	d. Child				
❑ Male ❑ Female	e. Child				
❑ Male ❑ Female	f. Child				
❑ Male ❑ Female	g. Child				

If you need to list additional dependents, please use lined paper, sign and date it, and check this box. ❑

Dec 15 2011 01:09:13 pm

4. Do all applicants, other than dependent children, read, write, speak, and understand the English language? . . . . . ❑ Yes ❑ No

COVERAGE INFORMATION — For additions and reinstatements, complete only if changing the deductible for all insureds.

5. Requested Effective Date: __ __/__ __ / __ __ __ __
6. All plans include a preferred network; if not wanted, check here ❑ Network Name:_____
7. Has any applicant smoked cigarettes or used tobacco in any form (including smokeless tobacco) or nicotine substitute within the past 12 months? (If yes, indicate who below.) . . . . . ❑ Yes ❑ No

a. Primary	b. Spouse	c.Child	d. Child	e. Child	f. Child	g. Child
❑ Yes	❑ Yes	❑ Yes	❑ Yes	❑ Yes	❑ Yes	❑ Yes

8. Deductible, if to be changed for all insureds: ❑ $1,000 ❑ $1,500 ❑ $2,000 ❑ $2,500 ❑ Other $_____

Special Instructions:_____

BILLING

9. **PREMIUM MODE**
   a. ❑ Quarterly ❑ Monthly EFT

   b. Premium for Mode Chosen $ _____

Special Instructions:_____

IMPORTANT: Premium will be verified and may be adjusted up or down during the underwriting process.

Dec 15 2011 01:09:13 pm

PREVIOUS OR CURRENT HEALTH INSURANCE COVERAGE (Completing this section may make you eligible for an earlier effective date for illnesses.)

Yes No

10. Within the last 63 days, has any applicant **been covered** by any type of **medical** insurance? . . . . . ❑ ❑
    If yes, complete chart below. 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

Yes No

11. Has any applicant ever had an application or policy voided, declined, rated, or had coverage modified (including medical exclusion riders) by any health or life insurer? (If yes, list name and give details.) . . . . . ❑ ❑
    Person: _____ Company: _____ Action Taken: _____
    Date: _____ Reason for Action: _____
12. Has any applicant previously applied for, or been covered by, Golden Rule or UnitedHealthcare? . . . . . ❑ ❑
    Name _____ Policy/Certificate Number _____

DRIVING — FOR ALL APPLICANTS

Yes No

13. 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)? **❑ a. Primary ❑ b. Spouse ❑ c. Child ❑ d. Child ❑ e. Child ❑ f. Child ❑ g. Child**
    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! YOU MUST PROVIDE DETAILS OF EACH YES ANSWER IN THE "MEDICAL HISTORY DETAILS" SECTION.

Yes No

14. Are you, or is any family member (whether or not named in this application), pregnant or an expectant mother or father, or in the process of surrogate pregnancy, or do you or any family member have an adoption pending? . . . . . ❑ ❑
15. In the last 5 years, has any applicant filed a claim and/or received benefits from disability insurance or Worker's Compensation? ❑ ❑
16. Has any applicant had or been advised to have: (a) any testing (other than routine testing, such as pap or mammogram); or (b) any treatment, which has not yet been completed? . . . . . ❑ ❑
17. In the last 6 months, has any applicant taken, or been advised to take, medication or received medical advice or treatment of any kind? . . . . . ❑ ❑
18. In the last 12 months, has any applicant experienced a weight gain or loss of 15 pounds or more? . . . . . ❑ ❑
19. In the last 5 years, has any applicant used an illegal drug; had any diagnosis or treatment of an alcohol or drug dependency, problem, or abuse; been advised to reduce alcohol intake; or had any alcohol- or drug-related moving violation, arrest, or driver's license suspension? . . . . . ❑ ❑
20. 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, or 1 oz. of hard liquor).

Dec 15 2011 01:09:13 pm

MEDICAL HISTORY — FOR ALL APPLICANTS (continued)

21. In the last 10 years, has any applicant:	Yes	No
a. Had a complicated pregnancy or delivery (including a caesarean section)?	❑	❑
b. Consulted a health care provider for any condition or symptom(s) for which a diagnosis has not been established?	❑	❑
c. Had any diagnosis or treatment of Acquired Immune Deficiency Syndrome (AIDS) or any HIV-related disease or illness, or tested positive for antibodies to the HIV virus?	❑	❑
d. Had any abnormal physical exam, X-ray, EKG, MRI, CT scan, or any adverse or abnormal laboratory or other test results?	❑	❑
e. Been confined in a hospital for anything other than childbirth?	❑	❑
f. Had surgery?	❑	❑
g. Had placement, treatment, or maintenance of an internal or external implant or prosthetic device?	❑	❑

In the last 10 years, has any applicant had testing or additional tests recommended for, or had any signs, symptoms, diagnosis, or treatment of, any disease, disorder, or abnormality of any of the following:

	Yes	No
22. Digestive System		
a. gallbladder, pancreas, or liver?	❑	❑
b. ulcers?	❑	❑
c. gastroesophageal reflux disease (acid reflux, GERD)?	❑	❑
d. rectal bleeding?	❑	❑
e. other digestive system disorder or condition?	❑	❑
23. Urinary System		
a. kidney?	❑	❑
b. other urinary system disorder or condition?	❑	❑
24. Eyes, Ears, Nose		
a. ear or sinus infections (more than two in the past 12 months)?	❑	❑
b. other disorder or condition of the eyes, ears, or nose?	❑	❑
25. Mouth, Throat, or Jaw	❑	❑
26. Skin Disorders	❑	❑
27. Heart or Circulatory System		
a. chest pain?	❑	❑
b. high or low blood pressure?	❑	❑
c. elevated cholesterol?	❑	❑
d. stroke?	❑	❑
e. shunts, stents, or pacemaker?	❑	❑
f. other heart or circulatory system disorder or condition?	❑	❑
28. Male or Female Reproductive System		
a. infertility or erectile dysfunction?	❑	❑
b. sexually transmitted disease?	❑	❑
c. abnormal mammogram or Pap smear?	❑	❑
d. other male or female reproductive system disorder or condition?	❑	❑

	Yes	No
29. Blood, Gland, Endocrine, or Metabolic		
a. thyroid, breast, or other glands?	❑	❑
b. diabetes or sugar in the blood or urine?	❑	❑
c. anemia?	❑	❑
d. immune system disorder (other than AIDS or HIV)?	❑	❑
e. other blood, endocrine, or metabolic disorder or condition?	❑	❑
30. Brain and Nervous System		
a. migraines or chronic or severe headaches?	❑	❑
b. seizures or epilepsy?	❑	❑
c. mental, emotional, or behavioral disorder (including anorexia or bulimia)?	❑	❑
d. multiple sclerosis or paralysis?	❑	❑
e. other brain or nervous system disorder or condition?	❑	❑
31. Muscular or Skeletal System		
a. joints, bones, spine, or back?	❑	❑
b. arthritis or fibromyalgia?	❑	❑
c. amputation?	❑	❑
d. other muscular/skeletal system disorder or condition?	❑	❑
32. Respiratory System		
a. asthma or allergies?	❑	❑
b. sleep apnea?	❑	❑
c. other respiratory system disorder or condition?	❑	❑
33. Cancer, Cyst, or Tumor		
a. cancer?	❑	❑
b. tumor, cyst, polyp, lump, or growth of any kind?	❑	❑
34. Birth Defects or Congenital Abnormalities		
a. Down's syndrome?	❑	❑
b. cerebral palsy?	❑	❑
c. other birth defect or congenital abnormality?	❑	❑

	Yes	No
35. In the last 5 years, has any applicant had any signs, symptoms, diagnosis, or treatment for any other disease, disorder, injury, or condition (excluding childbirth) that is not listed on this application?	❑	❑

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.

Dec 15 2011 01:09:13 pm

MEDICAL HISTORY DETAILS — FOR ALL APPLICANTS

Question Number: ____________ Person: ____________ Dates: ____________

Symptoms or Conditions: ____________

Prescriptions (include dose, how often taken, dates taken): ____________

Treatment, Advice Given, Results, and Other Details: ____________

Name, Address, Phone of Doctors, Hospitals, etc.: ____________

Question Number: ____________ Person: ____________ Dates: ____________

Symptoms or Conditions: ____________

Prescriptions (include dose, how often taken, dates taken): ____________

Treatment, Advice Given, Results, and Other Details: ____________

Name, Address, Phone of Doctors, Hospitals, etc.: ____________

Question Number: ____________ Person: ____________ Dates: ____________

Symptoms or Conditions: ____________

Prescriptions (include dose, how often taken, dates taken): ____________

Treatment, Advice Given, Results, and Other Details: ____________

Name, Address, Phone of Doctors, Hospitals, etc.: ____________

Question Number: ____________ Person: ____________ Dates: ____________

Symptoms or Conditions: ____________

Prescriptions (include dose, how often taken, dates taken): ____________

Treatment, Advice Given, Results, and Other Details: ____________

Name, Address, Phone of Doctors, Hospitals, etc.: ____________

If you need more space to provide complete and accurate information, please use lined paper, sign and date it, and check this box. ❑

SPECIAL INSTRUCTIONS

STATEMENT OF UNDERSTANDING — Review the completed application and read the section below carefully before signing.

I personally completed this application. I represent that the answers and statements on it are true, complete, and correctly recorded.

I understand and agree that:

(1) This application and the initial payment do not give me immediate coverage.

(2) I should not terminate existing coverage until I have accepted the Golden Rule coverage.

(3) Unless Golden Rule agrees to an earlier date, coverage for illness begins on the 15th day after a person becomes insured for injury.

(4) There will be no benefits for any loss incurred in the first year of coverage due to a preexisting condition (does not apply to applicants under the age of 19).

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

(6) This completed application, and any supplements or amendments, will be a part of any policy/certificate, if issued.

(7) The broker may only submit the application and initial payment, and may not promise me coverage, modify Golden Rule's underwriting policy or terms of coverage, or change or waive any right or requirement.

(8) The broker may receive copies of any correspondence about my medical history when correspondence is required.

(9) **If I continue other coverage existing on the Golden Rule effective date for more than 90 days after that date, the Golden Rule coverage will be void.**

(10) I must notify Golden Rule of any medical conditions or treatment arising between the date of this application and the effective date of my coverage.

(11) I represent that I have made such investigations as are necessary to assure the truth and accuracy of all statements made in this application regarding all listed dependents.

(12) If Golden Rule rejects this application, under no circumstances will any benefits be payable. Receipt of money, cashing of my check, or charging my credit card by Golden Rule does not constitute approval of my application or create Golden Rule coverage.

(13) Golden Rule may request additional information, and this may delay the processing of this application. If the health care provider charges a fee for these services, Golden Rule will determine its payment, and I will be responsible for any difference.

(14) Golden Rule has the right to rely upon the answers and statements in this application, without requesting medical records from any provider listed.

I have received a Notice of Information Practices and a Conditional Receipt or Conditions Prior to Coverage.

X _____
Primary Applicant (You)

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

X _____
Spouse (If to be covered)

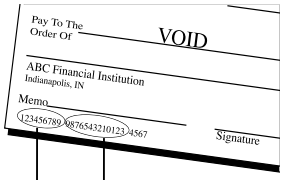
___/___/___
Date

Dec 15 2011 01:09:13 pm

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.



Type of Account: ❑ Checking ❑ Savings

Nine-digit Routing No. _____

Account No. _____

Financial Institution's Name _____

Address _____

City, State, ZIP _____

Draft On _____ _____

Day Date Signed

X _____

Authorized Account Signature

Email Address _____

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.

AUTHORIZATION TO OBTAIN AND DISCLOSE NONMEDICAL INFORMATION

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 MIB, Inc., formerly known as 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.

ANI-0311

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

Signed X ___/___/___
Date

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, pharmacy benefit manager, consumer-reporting agency, MIB, Inc., formerly known as 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 ___/___/___
Date

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

X _____
Signature of Primary Applicant (You)

X _____
Signature of Spouse (If to be covered)

36228-G-1111

Dec 15 2011 01:09:13 pm

KEEP FOR YOUR RECORDS

A COPY OF YOUR 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 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.

A COPY OF YOUR 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, pharmacy benefit manager, consumer-reporting agency, MIB, Inc., formerly known as 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.

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- 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.

36228-G-1111

Dec 15 2011 01:09:13 pm

NOTICE OF INFORMATION PRACTICES

THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We (including our affiliates listed at the end of this notice) are required by law to protect the privacy of your health information. We are also required to send you this notice, which explains how we may use information about you and when we can give out or "disclose" that information to others. You also have rights regarding your health information that are described in this notice.

The terms "information" or "health information" in this notice include any information we maintain that reasonably can be used to identify you and that relates to your physical or mental health or condition, the provision of health care to you, or the payment for such health care.

We have the right to change our privacy practices. If we do, we will provide the revised notice to you within 60 days by direct mail or post it on our websites located at *www.goldenrule.com* or *www.eams.com*

How We Use or Disclose Information

We must use and disclose your health information to provide information:

- To you or someone who has the legal right to act for you (your personal representative); and
- To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected.

We have the right to use and disclose health information to pay for your health care and operate our business. For example, we may use your health information:

- **For Payment** of premiums due us and to process claims for health-care services you receive.
- **For Treatment.** We may disclose health information to your physicians or hospitals to help them provide medical care to you.
- **For Health-Care Operations.** We may use or disclose health information as necessary to operate and manage our business and to help manage your health-care coverage. For example, we might conduct or arrange for medical review, legal services, and auditing functions, including fraud and abuse detection or compliance programs. We may use your health information for underwriting purposes; however, we are prohibited by law from using or disclosing genetic information for underwriting purposes.
- **To Provide Information on Health Related Programs or Products** such as alternative medical treatments and programs or about health-related products and services.
- **To Plan Sponsors.** If your coverage is through an employer group health plan, we may share summary health information and enrollment and disenrollment information with the plan sponsor. In addition, we may share other health information with the plan sponsor for plan administration if the plan sponsor agrees to special restriction on its use and disclosure of the information.
- **For Appointment Reminders.** We may use health information to contact you for appointment reminders with providers who provide medical care to you.

We may use or disclose your health information for the following purposes under limited circumstances:

- **As Required by Law.** We may disclose information when required by law.
- **To Persons Involved With Your Care.** We may use or disclose your health information to a person involved in your care, such as a family member, when you are incapacitated or in an emergency, or when permitted by law.
- **For Public Health Activities** such as reporting disease outbreaks.
- **For Reporting Victims of Abuse, Neglect or Domestic Violence** to government authorities, including a social service or protective service agency.
- **For Health Oversight Activities** such as governmental audits and fraud and abuse investigations.
- **For Judicial or Administrative Proceedings** such as in response to a court order, search warrant or subpoena.
- **For Law Enforcement Purposes** such as providing limited information to locate a missing person.
- **To Avoid a Serious Threat to Health or Safety** by, for example, disclosing information to public health agencies.
- **For Specialized Government Functions** such as military and veteran activities, national security and intelligence activities, and the protective services for the President and others.
- **For Workers Compensation** including disclosures required by state workers compensation laws of job-related injuries.
- **For Research Purposes** such as research related to the prevention of disease or disability, if the research study meets all privacy law requirements.
- **To Provide Information Regarding Decedents.** We may disclose information to a coroner or medical examiner to identify a deceased person, determine a cause of death, or as authorized by law. We may also disclose information to funeral directors as necessary to carry out their duties.
- **For Organ Procurement Purposes.** We may use or disclose information for procurement, banking or transplantation of organs, eyes or tissue.
- **To Correctional Institutions or Law Enforcement Officials** if you are an inmate of a correctional institution or under the custody of a law enforcement official, but only if necessary (1) for the institution to provide you with health care; (2) to protect your health and safety or the health and safety of others; or (3) for the safety and security of the correctional institution.
- **To Business Associates** that perform functions on our behalf or provide us with services if the information is necessary for such functions or services. Our business associates are required, under contract with us, to protect the privacy of your information and are not allowed to use or disclose any information other than as specified in our contract. As of 2/17/10, our business associates are also directly subject to federal privacy laws.
- **For Data Breach Notification Purposes.** We may use your contact information to provide legally-required notices of unauthorized acquisition, access, or disclosure of your health information.
- **Additional Restrictions on Use and Disclosure.** Certain federal and state laws may require special privacy protections that restrict the use and disclosure of certain health information, including highly confidential information about you. "Highly confidential information" may include confidential information under federal laws governing alcohol and drug abuse information and genetic information as well as state laws that often protect the following types of information: HIV/AIDS; mental health; genetic tests; alcohol and drug abuse; sexually transmitted diseases and reproductive health information; and child or adult abuse or neglect, including sexual assault.

If none of the above reasons applies, **then we must get your written authorization to use or disclose your health information.** If a use or disclosure of health information is prohibited or materially limited by other applicable law, it is our intent to meet the requirements of the more stringent law. In some states, your authorization may also be required for disclosure of your health information. Authorization is required for the use and disclosure of psychotherapy notes or for marketing. In many states, your authorization may be required in order for us to disclose your highly confidential health information. Once you give us authorization to release your health information, we cannot guarantee that the person to whom the information is provided will not disclose the information. You may take back or "revoke" your written authorization, except if we have already acted based on your authorization. To revoke an authorization, contact the phone number listed on your ID card.

What Are Your Rights

The following are your rights with respect to your health information.

- **You have the right to ask to restrict** uses or disclosures of your information for treatment, payment, or health-care operations and to ask to restrict disclosures to family members or to others who are involved in your health care or payment for your health care. We may also have policies on dependent access that may authorize certain restrictions. **Please note that while we will try to honor your request and will permit requests consistent with its policies, we are not required to agree to any restriction.**
- **You have the right to request that a provider not send health information** to us in certain circumstances if the health information concerns a health-care item or service for which you have paid the provider out of pocket in full.
- **You have the right to ask to receive confidential communications** of information in a different manner or at a different place (for example, by sending information to a P.O. Box instead of your home address). We will accommodate reasonable requests where a disclosure of all or part of your health information otherwise could endanger you. We will accept verbal requests to receive confidential communications, but request to modify or cancel a previous confidential communication request must be made in writing. Mail your request to the address listed below.
- **You have the right to see and obtain a copy** of health information that may be used to make decisions about you such as claims and case or medical management records. You also may receive a summary of this health information. You must make a written request to inspect and copy your health information. In certain limited circumstances, we may deny your request to inspect and copy your health information.
- **You have the right to ask to amend information** we maintain about you if you believe the health information about you is wrong or incomplete. We will notify you within 30 days if we deny your request and provide a reason for our decision. If we deny your request, you may have a statement of your disagreement added to your health information. We will notify you in writing of any amendments we make at your request. We will provide updates to all parties that have received information from us within the past two years (seven years for support organizations).
- **You have the right to receive an accounting** of certain disclosures of your information made by us during the six years prior to your request. This accounting will not include disclosures of information: (i) made prior to April 14, 2003; (ii) for treatment, payment, and health-care operations purposes; (iii) to you or pursuant to your authorization; and (iv) to correctional institutions or law enforcement officials; and (v) that federal law does not require us to provide an accounting.
- **You have the right to a paper copy of this notice.** You may ask for a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice upon request. In addition, you may obtain a copy of this notice at our websites, *www.eAMS.com* or *www.goldenrule.com*.
- In New Mexico, you have the right to be considered a protected person. A "protected person" is a victim of domestic abuse who also is either: (1) an applicant for insurance with us: (2) a person who is or may be covered by our insurance; or (3) someone who has a claim for benefits under our insurance.

Exercising Your Rights

- **Contacting your Health Plan.** If you have any questions about this notice or want to exercise any of your rights, call the phone number on your ID card.
- **Filing a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with us at the following address:
- Privacy Officer, Golden Rule Insurance Company, 7440 Woodland Drive, Indianapolis, IN 46278-1719
- **You may also notify the Secretary of the U.S. Department of Health and Human Services of your complaint.** We will not take any action against you for filing a complaint.

Fair Credit Reporting Act Notice

In some cases, we may ask a consumer-reporting agency to compile a consumer report, including potentially an investigative consumer report, about you. If we request an investigative consumer report, we will notify you promptly with the name and address of the agency that will furnish the report. You may request in writing to be interviewed as part of the investigation. The agency may retain a copy of the report. The agency may disclose it to other persons as allowed by the federal Fair Credit Reporting Act.

We may disclose information solely about our transactions or experiences with you to our affiliates.

Medical Information Bureau

In conjunction with our membership in MIB, Inc., formerly known as Medical Information Bureau (MIB), we or our reinsurers may make a report of your personal information to MIB. MIB is a nonprofit organization of life and health insurance companies that operates an information exchange on behalf of its members.

If you submit an application or claim for benefits to another MIB member company for life or health insurance coverage, the MIB, upon request, will supply such company with information regarding you that it has in its file.

If you question the accuracy of information in the MIB's file, you may seek a correction in accordance with the procedures set forth in the federal Fair Credit Reporting Act. Contact MIB at: MIB, Inc., 50 Braintree Hill Ste. 400, Braintree, MA 02184-8734, (866) 692-6901, *www.mib.com* or (TTY) (866) 346-3642.

FINANCIAL INFORMATION PRIVACY NOTICE

We (including our affiliates listed at the end of this notice) are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information, other than health information, about an insured or an applicant for health-care coverage that identifies the individual, is not generally publicly available and is collected from the individual or is obtained in connection with providing health-care coverage to the individual.

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age and social security number; and
- Information about your transactions with us, our affiliates or others, such as premium payment history.

We do not disclose personal financial information about our insureds or former insureds to any third party, except as required or permitted by law.

We restrict access to personal financial information about you to employees, affiliates and service providers who are involved in administering your health-care coverage or providing services to you. We maintain physical, electronic and procedural safeguards that comply with federal standards to guard your personal financial information.

Send written requests to access, correct, amend or delete information to:

- Privacy Officer, Golden Rule Insurance Company, 7440 Woodland Drive, Indianapolis, IN 46278-1719

We may disclose personal financial information to financial institutions which perform services for us. These services may include marketing our products or services or joint marketing of financial products or services.

The Notice of Information Practices , effective November 2010, is provided on behalf of American Medical Security Life Insurance Company; Golden Rule Insurance Company; PacifiCare Life and Health Insurance Company; PacifiCare Life Assurance Company, UnitedHealthcare Insurance Company, All Savers Insurance Company; and All Savers Life Insurance Company of California.

To obtain an authorization to release your personal information to another party, please go to appropriate website listed at the bottom of the page.