

Select a plan, coverage period from 1 to 6 months, and a deductible that fits your budget.

## Short Term Medical<sup>SM</sup> Plus

- Offers more coverage than our Value plan. Great for those seeking predictable out-of-pocket expenses.
- You select the length of coverage (term) you need, from 1 to 6 months, and the **deductible** amount (you pay) **for the selected time period** (term).

## Short Term Medical<sup>SM</sup> Value

- Costs less than our Plus plan. In exchange, you take more responsibility for medical expenses.
- You select the length of coverage (term) you need, from 1 to 6 months, and the **deductible** amount (you pay) **for EACH illness or injury** (cause).

## Why Choose Us for Health Insurance?

### UnitedHealthcare

Approximately 25 million customers entrust UnitedHealthcare with their health insurance needs.\* Our network plans can ease access to high-quality care from physicians and hospitals nationwide. Together, we combine our strength and stability with nearly three decades of experience serving customers of all sizes.

### UnitedHealthOne

UnitedHealthOne is the brand name of the UnitedHealthcare family of companies that offers personal health insurance products. Golden Rule Insurance Company, a UnitedHealthcare company, is the underwriter and administrator of these plans. With over 65 years of experience serving individuals and families, Golden Rule provides high-quality products, timely claims handling, and outstanding customer service.

### Experience and Expertise

Golden Rule's experience and expertise has driven the development of easy-to-use and innovative health insurance products. A recognized leader — and one of the nation's largest providers of health savings account plans — Golden Rule continues building plans that meet the needs of individuals and families.

845D-G-0511

\* UnitedHealth Group Annual Form 10-K for year ended 12/31/10.

## 1) Connecticut Monthly Base Premium Rates

### Short Term Medical<sup>SM</sup> Plus

Primary* & Spouse Age	\$500 Deductible		\$1,000 Deductible		\$1,500 Deductible		\$2,500 Deductible		\$5,000 Deductible		\$10,000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
13-24	68	63	48	42	43	38	34	30	28	24	22	20
25-29	68	72	49	50	44	45	35	36	28	29	23	23
30-34	74	83	52	59	47	52	37	42	30	33	24	27
35-39	80	95	56	66	50	59	40	47	32	38	26	31
40-44	98	110	72	77	65	69	52	55	41	44	34	36
45-49	118	127	89	93	80	84	64	67	51	53	41	43
50-54	150	152	116	116	104	104	83	83	66	66	54	54
55-59	201	180	158	141	141	126	113	100	90	80	73	65
60-64	248	204	194	160	173	143	138	114	111	92	90	74
Per Dependent Child	34	34	22	22	20	20	16	16	13	13	10	10

### Short Term Medical<sup>SM</sup> Value

Primary* & Spouse Age	\$500 Deductible		\$1,000 Deductible		\$1,500 Deductible		\$2,500 Deductible		\$5,000 Deductible	
	Male	Female	Male	Female	Male	Female	Male	Female	Male	Female
13-24	58	54	41	36	36	32	28	25	23	20
25-29	58	62	41	43	37	38	29	29	23	24
30-34	63	71	44	50	39	44	31	34	24	27
35-39	68	81	48	56	42	50	33	39	26	31
40-44	84	94	61	65	54	58	42	45	34	36
45-49	101	109	76	79	67	70	52	55	42	44
50-54	129	130	98	99	87	88	68	68	54	54
55-59	172	154	134	119	119	106	93	82	74	66
60-64	212	175	164	136	146	121	114	94	91	75
Per Dependent Child	29	29	19	19	17	17	13	13	10	10

## 3) Trend Factor

Effective Date	Trend Factor
Through June 2011	1.08
July - September 2011	1.12
October 2011 and later	1.16

## 4) ZIP Code Area Factor

ZIP Code	Factor
060-067	1.000
068, 069	1.100

\*Primary must be age 19 or older

Please read the Short Term Medical<sup>SM</sup> plans brochure and this separate, state-specific application and payment information thoroughly and carefully.

**Premium Calculation Instructions (Use Charts On Left)**

<p><b>1) Monthly Base Premium Rate.</b> Find the rate for each person applying. Rates are based on plan, deductible, gender, and age (as of effective date).</p>	<p><b>1) Find Your Rate (see chart on left)</b>  <b>a) Your Rate</b> .....  <b>b) Spouse Rate</b>.....  <b>c) Child Rate (no. of children ____ x \$____)</b>.....  <b>Subtotal =</b></p>	<p>+ _____            + _____            _____</p>	
<p><b>2) Multiple Person Discount.</b> If more than one person is applying, multiply Subtotal by 0.90.</p>	<p><b>2) Multiple Person Discount</b>.....  <b>(1 person = 1.00) (2 or more = .90)</b>  <b>Subtotal =</b></p>	<p><b>x</b> _____            _____</p>	
<p><b>3) Trend Factor.</b> Your effective date determines the Trend Factor.</p>	<p><b>3) Trend Factor (see chart on left)</b>.....  <b>Subtotal =</b></p>	<p><b>x</b> _____            _____</p>	
<p><b>4) ZIP Code Area Factor.</b> Multiply Subtotal by ZIP Code Area Factor.</p>	<p><b>4) ZIP Code Area Factor (see chart on left)</b>.....  <b>Subtotal =</b></p>	<p><b>x</b> _____            _____</p>	
<p><b>Two Payment Options:</b> You can choose <b>Monthly Payments</b> or <b>Single Payment</b>.  <b>5) For Monthly Payment option only,</b> multiply by 1.15.</p>	<p><b>5) Monthly Processing Factor (if paying monthly)</b>.....  <b>Subtotal =</b></p>	<p><b>Monthly Payments</b></p>	<p><b>Single Payment</b></p>
		<p><b>x 1.15</b>            _____</p>	<p><b>N/A</b>  <b>N/A</b></p>
<p><b>6) For Single Payment Option only – multiply by number of months you want coverage.</b></p>	<p><b>6) Number of Months (if applicable) (1 to 6)</b>.....  <b>Subtotal =</b></p>	<p><b>N/A</b></p>	<p><b>x</b> _____            _____</p>
<p><b>7) One-Time Application Fee.</b>            (Additional Payments will not include this fee.)</p>	<p><b>7) \$20 Application Fee (one-time fee)</b>.....  <b>Total Payment Payable to Golden Rule =</b></p>	<p><b>+ \$20.00</b>            \$ _____  <b>Total Initial Payment</b></p>	<p><b>+ \$20.00</b>            \$ _____  <b>Total Single Payment</b></p>

**If Monthly EFT Payment option:** Complete the **Monthly Payment: Electronic Funds Transfer (EFT) Authorization** section.

**If Single Payment option:** Make check or money order payable to Golden Rule, or complete the **Single Payment: Credit Card** section if you are paying by credit card.

Please Print  
in Blue Ink.

APPLICATION FOR SHORT TERM MEDICAL<sup>SM</sup> INSURANCE  
GOLDEN RULE INSURANCE COMPANY — LAWRENCEVILLE, ILLINOIS 62439

THIS PLAN IS ISSUED ON AN INDIVIDUAL BASIS AND IS REGULATED AS AN INDIVIDUAL HEALTH INSURANCE PLAN.

PROPOSED  
INSURED

\_\_\_\_\_  
First Middle Initial Last

\_\_\_\_/\_\_\_\_/\_\_\_\_ \*  
Birth Date

\_\_\_\_  
Age

Male  
 Female  
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 Name (Last, First, M.I.)	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. Have you or any person named on this application been covered by a previous short term policy with Golden Rule within the last 35 days?.....  Yes  No
3. Are you or is any family member (whether or not named in this application) an expectant mother or father? **If yes, coverage cannot be issued.**.....  Yes  No
4. Have you or has anyone named above been declined for insurance due to health reasons?.....  Yes  No  
If yes, state the name of each person: \_\_\_\_\_  
(The person(s) named will not be covered under the policy.)
5. 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**....  Yes  No  
the past 12 months? If yes, state the name of each person: \_\_\_\_\_  
(The person(s) named will not be covered under the policy.)
6. Do you or does any person named in Question 1 now have hospital or medical expense insurance that **will not** terminate.....  Yes  No  
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.)
7. 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?.....  Yes  No  
If yes, state the name of each person: \_\_\_\_\_  
(The person(s) named will not be covered under the policy.)

PLAN:  Short Term Medical<sup>SM</sup> Plus  Short Term Medical<sup>SM</sup> Value

DEDUCTIBLE:  \$ 500  \$ 1,000  \$ 1,500  \$ 2,500  \$ 5,000  
 \$ 10,000 (not available with Short Term Medical<sup>SM</sup> Value)

MONTHS OF COVERAGE:  1  2  3  4  5  6

REQUESTED EFFECTIVE DATE: \_\_\_\_/\_\_\_\_/\_\_\_\_

STATEMENT OF UNDERSTANDING

I have read this application and represent that the information shown on it is true and complete to the best of my knowledge and belief. 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) 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. 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

\_\_\_\_\_  
Licensed Agent or Broker (Please Print.) Individual Producer #

**This policy excludes coverage for conditions for which medical advice, diagnosis, care, or treatment was recommended or received during the twenty-four months immediately preceding the effective date of coverage.**

Important Note:  
"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.

**PAYOR INFORMATION (If other than Proposed Insured)**

Payor: \_\_\_\_\_  
Name Email Address  
\_\_\_\_\_  
Street City State ZIP

**PAYMENT OPTIONS: SINGLE OR MONTHLY**

**Initial Payment With Application:**

**Single Payment** (one single payment for all months chosen/lump sum):

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

**Credit card \$ Amount** \_\_\_\_\_ (Total Single Payment on reverse. Includes \$20 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 \_\_\_\_/\_\_\_\_/\_\_\_\_ Billing ZIP Code \_\_\_\_\_ X \_\_\_\_\_  
Signature of Authorized User

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

OR

**Monthly Payment:**

**Initial Payment**  Check or money order payable to Golden Rule.  EFT (online application only)  
**\$ Amount** \_\_\_\_\_ (Total Initial Payment on reverse. First month amount (shown) includes a one-time \$20 application fee.)

**Ongoing Payments (Choose one)**

**Direct Bill** (\$10 monthly billing fee)  
Additional monthly Direct Bill payments will not include the \$20 application fee, however they will include a \$10 monthly billing fee.

**Electronic Funds Transfer (EFT)** (no billing fee)  
Additional monthly EFT payments will not include the \$20 application fee. For this method of payment, you must complete the EFT Authorization below.

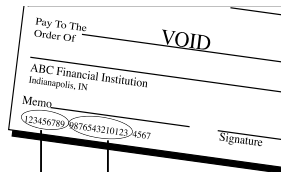
**ELECTRONIC FUNDS TRANSFER (EFT) AUTHORIZATION — ONLY IF PAYING BY EFT**

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.