

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 Email Address

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

Table with columns: Name (Last, First, M.I.), Relationship, Birth Date, Gender. Includes a 'Spouse' entry.

PAYOR:

(If not You): Name Email Address Street City State ZIP

1. Are you or any dependent intending to replace current in force dental or vision, (if applicable) insurance? REQUESTED EFFECTIVE DATE: (See Statement of Understanding section.)

- Plan Choices: UnitedHealthcare Dental Premier, UnitedHealthcare Dental Value
OPTIONAL: UnitedHealthcare Vision
Payment Mode: Monthly, Quarterly, Semi-annual, Annual
Payment Options: Initial Payment with Application: Check, EFT, Credit Card
Ongoing Payments: Monthly EFT, Direct Bill, List 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...

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

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.





**CALCULATE YOUR PREMIUM** (Rates subject to change without notice, verify rate at [www.uhone.com/quote](http://www.uhone.com/quote))

**1 CONNECTICUT DENTAL BASE RATES**

UnitedHealthcare <i>Dental Premier</i>	<b>1 Person</b>	<b>2 People</b>	<b>3+ People</b>
Statewide	42.48	84.11	148.68
UnitedHealthcare <i>Dental Value</i>			
Statewide	25.52	50.53	89.32

**2 TREND FACTORS**

<b>Effective Dates</b>	<b>Premier Factor</b>	<b>Value Factor</b>
July through September 2011	1.214	1.330
October through December 2011	1.231	1.350
January through March 2012	1.249	1.370
April 2012 and Later	1.268	1.390

**3 CONNECTICUT VISION RATES**

	<b>1 Person</b>	<b>2 People</b>	<b>3+ People</b>
Statewide	9.00	16.00	24.00

**4 PAYMENT MODE FACTORS**

<b>Modes</b>	<b>Factor</b>
Monthly	1
Quarterly	3
Semi-annual	6
Annual	12

**PREMIUM CALCULATION**

Dental Base Rate for Plan Chosen <b>1</b> .....		_____
Trend Factor <b>2</b> .....	x	_____
Subtotal .....	=	_____
Vision Rate <b>3</b> .....	+	_____
Subtotal .....	=	_____
Payment Mode Factor <b>4</b> .....	x	_____
<b>Premium for Mode Chosen*</b> .....	=	_____

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

**NOTICE TO APPLICANT REGARDING REPLACEMENT OF DENTAL INSURANCE**

GOLDEN RULE INSURANCE COMPANY: 7440 WOODLAND DRIVE • INDIANAPOLIS, INDIANA 46278-1719

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

According to your application or information you have furnished, you intend to lapse or otherwise terminate existing dental insurance and replace it with a policy to be issued by Golden Rule Insurance Company. For your own information and protection, you should be aware of and seriously consider certain factors which may affect the insurance protection available to you under the new policy.

1. You may wish to secure the advice of your present insurer or its agent regarding the proposed replacement of your present policy. This is not only your right, but it is also in your best interest to make sure you understand all the relevant factors involved in replacing your present coverage.

2. If, after due consideration, 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. Failure to include all material 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, re-read it carefully to be certain that all information has been properly recorded.

Also, if you are issued coverage, carefully check the application again and write to Golden Rule Insurance Company at the address shown at the top of this notice within 10 days if any information is not correct and complete.

The above "Notice to Applicant" was delivered to me on:

\_\_\_\_\_ Date

\_\_\_\_\_ Applicant's Signature

**Applicant's Copy**

722D-G

0609

**Mail completed application to:**  
 Golden Rule Insurance Company  
 PO Box 31370  
 Salt Lake City, UT 84131-0370