

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.

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

PAYOR:

(If not You): Name E-mail Address
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

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 (include forms; \$25 monthly admin. fee per list bill group)

STATEMENT OF UNDERSTANDING

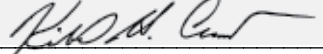
I have read this application and represent that the information shown on it is true and complete. I understand that: (a) no insurance will become effective unless my application is approved and the appropriate premium is actually received by Golden Rule with this application; (b) if other dental/vision 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.

Any person who knowingly and with intent to injure, defraud, or deceive any insurer files a statement of claim or an application containing any false, incomplete, or misleading information is guilty of a felony of the third degree.

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

X _____
FL Agent License Number

X  _____
Countersigned by Licensed Resident Agent

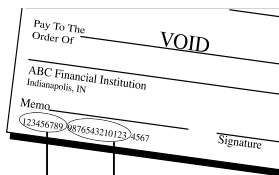
IMPORTANT NOTES: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service. No application will be accepted if received by Golden Rule more than 15 days after the date signed. Altered applications will not be accepted.

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.



Type of Account: Checking Savings

Nine-digit Routing No.

Acct No.

Financial Institution's Name

Address

City, State, ZIP

Draft On

Day Date Signed

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.

X

Authorized Account Signature

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

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

CALCULATE YOUR PREMIUM

1 FLORIDA DENTAL BASE RATES

UnitedHealthcare <i>Dental Premier</i>	1 Person	2 People	3+ People
ZIP Codes 320-329, 335-339, 341, 342, 344, 346, 347, 349	31.46	62.29	110.11
ZIP Codes 330-334	46.19	91.46	161.67

UnitedHealthcare <i>Dental Value</i>	1 Person	2 People	3+ People
ZIP Codes 320-329, 335-339	20.84	41.26	72.94
ZIP Codes 330-334	27.21	53.88	95.24

2 TREND FACTORS

Effective Dates	Factor
July through September 2009	1.045
October through December 2009	1.060
January through March 2010	1.075
April through June 2010	1.090
July through September 2010	1.105

3 FLORIDA 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

Dental Base Rate for Plan Chosen 1		<input type="text"/>
Trend Factor 2	x	<input type="text"/>
Subtotal	=	<input type="text"/>
Vision Rate 3	+	<input type="text"/>
Subtotal	=	<input type="text"/>
Payment Mode Factor 4	x	<input type="text"/>
Premium for Mode Chosen*	=	<input type="text"/>

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