

**APPLICATION FOR DENTAL INSURANCE
GOLDEN RULE INSURANCE COMPANY — INDIANAPOLIS, INDIANA**

PLEASE PRINT IN BLUE INK

APPLICANT(S) INFORMATION

PROPOSED INSURED: _____ Male Female
 First Name Middle Initial Last Name Birth Date: Month Day Year Age Gender

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.

First Name	Relationship	Birth Date	Gender	First Name	Relationship	Birth Date	Gender
	Spouse	/ /	<input type="checkbox"/> M <input type="checkbox"/> F			/ /	<input type="checkbox"/> M <input type="checkbox"/> F
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F			/ /	<input type="checkbox"/> M <input type="checkbox"/> F
		/ /	<input type="checkbox"/> M <input type="checkbox"/> F			/ /	<input type="checkbox"/> M <input type="checkbox"/> F

PAYOR: _____
 (If not You): Name E-mail Address

 Street City State ZIP

- 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
- 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? Yes No
 If yes, state the name of each person: _____
 (The person(s) named will not be covered under the policy.)
- Do you or does any applicant now have dental insurance that **will not** terminate prior to the requested effective date? Yes No
 If yes, state the name of each person:
 (The person(s) named will not be covered under the policy.)



REQUESTED EFFECTIVE DATE: ____/____/____

(See Statement of Understanding section.)

Plan Choices: UnitedHealthcare Dental PremierSM UnitedHealthcare Dental ValueSM (if available)

Payment Mode: Monthly Quarterly Semi-annual Annual

Payment Options: Initial Payment with Application: Check EFT Credit Card

Ongoing Payments: Monthly EFT Direct 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 and the appropriate premium is actually received by Golden Rule with this application; (b) if other dental insurance exists that duplicates coverage under the dental plan being applied for, the existing dental 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

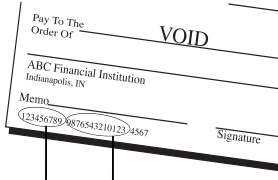
IMPORTANT NOTES: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service. No application will be accepted if received by Golden Rule more than 15 days after the date signed. Altered applications will not be accepted.

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.*

Type of Card: MasterCard Visa

Exp. Date:

____/____
Month

____/____
Year

Name as Printed on Card: _____

Billing Address _____ City _____ State _____ ZIP _____

Card Number: _____

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 320-322, 327-329, 335-339, 341, 342, 344, 346, 347, 349	20.84	41.26	72.94
ZIP Codes 330-334	27.21	53.88	95.24

2 TREND FACTORS

Effective Dates	Factor
Through December 2008	1.000
January through March 2009	1.015
April through June 2009	1.030
July through September 2009	1.045

3 PAYMENT MODES

Modes	Factor
Monthly	1
Quarterly	3
Semi-annual	6
Annual	12

PREMIUM CALCULATION

1 Dental Base Rate for Plan Chosen		_____
2 Trend Factor	X	_____
3 Subtotal	=	_____
4 Payment Mode	X	_____
Premium for Mode Chosen*	=	_____

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