

An Absolute Broker

FAX/MAIL COVER LETTER

****Please FAX or MAIL this cover letter with the completed application to:**

An Absolute Broker (mailing address below)

FAX# 775.522.7777

Dear An Absolute Broker,

Please accept my completed application for submittal and contact me to confirm receipt of this application

Name _____

E-mail _____

Date _____

Time _____

Please contact me at this phone number _____
after you have reviewed my application for completeness and accuracy.

I will contact An Absolute Broker at 910.232.4964 to verify receipt of my application.

****I understand that An Absolute Broker will not review this application until the following business day if I faxed this application after 5:00PM or on a weekend**

I understand that the original, signed application and premium payment must still be mailed to An Absolute Broker. :

**An Absolute Broker
Attn: New Enrollment
1319 Military Cutoff Rd #188
Wilmington, NC 28405**

I will send the original, signed application and premium payment, as soon as I have been contacted by An Absolute Broker with confirmation that my application has been received by fax and reviewed for completeness.

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 'Spouse' as a pre-filled relationship.

PAYOR: (If not You): Name E-mail Address Street City State ZIP

- 1. Do you or does any applicant now have dental insurance that will not terminate prior to the requested effective date?
2. 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 (quarterly, semi-annual and annual only)

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.

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

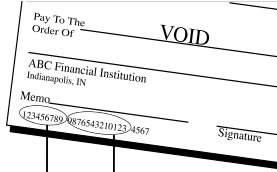
IMPORTANT NOTES: "Postmark date" means the date of the postmark as affixed by the U.S. Postal Service. No application will be accepted if received by Golden Rule more than 15 days after the date signed. Altered applications will not be accepted.

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

Card Number:

X

Signature of Authorized User

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

CALCULATE YOUR PREMIUM

1 SOUTH CAROLINA DENTAL BASE RATES

UnitedHealthcare <i>Dental Premier</i> Statewide	1 Person	2 People	3+ People
	34.03	67.38	119.11
UnitedHealthcare <i>Dental Value</i> ZIP Code 294			
	22.79	45.12	79.77

2 TREND FACTORS

Effective Dates	Factor
April through June 2010	1.090
July through September 2010	1.105
October through December 2010	1.120
January through March 2011	1.135
April through June 2011	1.150
July through September 2011	1.165
October through December 2011	1.180
January through March 2012	1.195

3 SOUTH CAROLINA 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).