



A. General Information (please print)

1. a. Member's Name (First, Middle, Last)
b. Address (No., Street)
c. City, State & ZIP
2. For Telephone Interview
Best Phone No.
Place to Call
3. a. Member's Employer
b. Occupation/Title/Duties
4. Spouse's Name (First, Middle, Last)
5. a. Spouse's Employer
b. Occupation/Title/Duties
6. Persons proposed for insurance.
7. a. Parent/Guardian (if child-only coverage)
8. a. Payor (if different from above)
9. Provide details under Additional Remarks in Section F for any questions answered "No".

B. Type of Coverage Requested

1. Name and Plan (Proposal must be attached to application when submitted):
Flex Advantage
HD Advantage
Value Advantage

Administrative Use Only

Please complete if Life Benefit for Covered Member selected: (If no beneficiary is designated, benefit will be paid to the estate of the insured.)
Beneficiary (First, Middle Initial, Last)
Social Security No.
Relationship

If designated beneficiary is a minor (under 18), provide name of guardian who will hold proceeds in trust until beneficiary reaches age 18:

2. Name of PPO Selected:
3. Please check your choice of effective date of coverage:
4. Individual Dental (Dental proposal must be attached to application when submitted)
5. Payment Mode:
Payment of Initial Premium:



**6. If "yes" for any proposed insured, please complete section below and submit any required replacement forms.** Yes  No

a. In the 90 days prior to the requested effective date of this certificate, is there any medical coverage (individual or group) in force or pending, including Medicare?

Name	Name of Insurance Company	Address for Insurance Carrier	Type of Plan	Start Date	Termination Date

b. Does any proposed insured agree to discontinue any inforce or pending coverage upon the issue of a World certificate?    
If "no", explain under Additional Remarks in Section F? .....

c. Is replacement or change of existing medical insurance in this company or elsewhere for any proposed insured involved in this application?

d. Are any of the persons proposed for insurance covered by Medicare? If "yes", explain under Additional Remarks in Section F?..

**7. Health Insurance Portability and Accountability Act of 1996 (HIPAA) — Eligible Individual Determination.**

HIPAA requires that each health insurance issuer that offers health insurance in the individual market (as defined by HIPAA) in a state may not decline to offer coverage to, nor deny enrollment of an individual who meets the definition of an "Eligible Individual" under federal law, nor may the issuer impose any preexisting condition exclusions on that individual with respect to such coverage.

**Please indicate "Yes" or "No" to the following:** Yes  No

a. As of the date on which you are applying for coverage, have you been insured under creditable coverage for at least 18 months with no more than a 62-day gap?

b. Was your most recent period of creditable coverage under a group health plan (employer-sponsored), a governmental plan, or a church plan?

c. If you were offered the option of continuation of coverage under COBRA or a similar state continuation program, did you complete the allowable period of coverage as an insured or dependent?    
If "No", please explain \_\_\_\_\_

d. Are you eligible for any of the following as an insured or dependent (check appropriate box):

- 1. a Group Health Plan?
- 2. Part A or Part B of Medicare?
- 3. a State plan under Medicaid, or successor program?

e. Do you have other health insurance?

f. Was your most recent health insurance terminated for nonpayment of premiums, misrepresentation or fraud?

g. Does your current employer or your spouse's employer, offer a group health plan (employer-sponsored)?    
If "Yes", provide the reason you decline to enroll: \_\_\_\_\_

h. Please provide your prior employer's name, complete address, and telephone number: \_\_\_\_\_  
\_\_\_\_\_

Dates of prior employment — From \_\_\_\_\_ to \_\_\_\_\_

If you answered "Yes" to questions a. through c., and "No" to questions d. through g., you meet the definition of a HIPAA "eligible individual".

**Please check appropriate box:**

- i. I am electing to apply as an "Eligible Individual" with no preexisting limitation. I understand that the rates for the "Eligible Individual" plan will be substantially higher than the underwriting plan rates.
- j. I am electing to be underwritten and as such I understand that I am waiving my right to apply for coverage as an "Eligible Individual". If you are denied coverage or have conditions excluded, this waiver will not be applicable if you wish to purchase a policy/certificate as an eligible individual. The date this application is signed will be the date for eligible individual status.

**If you check i. above, please attach your certification(s) of creditable coverage for the past 18 months to this application.**

**C. Health Statement**

1. Is the applicant, spouse or any dependent child (even if not proposed for insurance) now pregnant or an expectant father?

**If "yes", medical coverage cannot be issued.**

2. When did you, the **Proposed Insured**, last consult a physician, chiropractor or other practitioner? Month/Year \_\_\_\_\_

Name of physician or clinic \_\_\_\_\_ Phone Number \_\_\_\_\_

Address \_\_\_\_\_

Reason for consultation \_\_\_\_\_ Tests Performed \_\_\_\_\_

Findings \_\_\_\_\_

Remaining effects \_\_\_\_\_

How much has your weight changed in the past year?  None  Gained \_\_\_\_\_ lbs.  Lost \_\_\_\_\_ lbs.

Cause of weight change  Self-diet  Physician Recommended  Unknown  Medication \_\_\_\_\_

**3. To be completed by spouse if applying for coverage.**

When did you, the **Spouse**, last consult a physician, chiropractor or other practitioner? Month/Year \_\_\_\_\_  
 Name of physician or clinic \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Address \_\_\_\_\_  
 Reason for consultation \_\_\_\_\_ Tests Performed \_\_\_\_\_  
 Findings \_\_\_\_\_  
 Remaining effects \_\_\_\_\_  
 How much has your weight changed in the past year?  None  Gained \_\_\_\_\_ lbs.  Lost \_\_\_\_\_ lbs.  
 Cause of weight change  Self-diet  Physician recommended  Unknown  Medication \_\_\_\_\_

**If you answer "yes" to any of the following questions (4a-4l), please provide details in Section D.**

- 4. Has any person** proposed for insurance: Yes No
- a. ever been declined, postponed, ridered, or charged an extra premium for insurance?
  - b. ever been convicted of a felony?
  - c. ever been evaluated or treated for alcoholism, frequently used alcoholic beverages to excess or intoxication, or been advised to modify drinking habits for any reason?
  - d. ever used sedatives, tranquilizers, cocaine, marijuana, hallucinogenic, other narcotic drugs or controlled substances, or received treatment or evaluation for drug abuse or chemical dependency?
  - e. ever had surgery or diagnostic testing or treatment, or has surgery or diagnostic testing been recommended or scheduled that has not been completed?
  - f. ever had, been diagnosed or treated by a physician for any immune system disorder, including AIDS/ARC or positive HIV or HIV-related test disclosure limited to FDA-licensed blood test?
  - g. ever received disability benefits or currently disabled?
  - h. had any fixation/prosthetic devices that are currently present, including but not limited to, plates, screws, pins, implants (including breast implants), pacemakers, valve replacements or transplants?
  - i. in the past 10 years been in a hospital, clinic, or other medical facility for treatment, confinement or observation?
  - j. in the past 5 years participated in any racing, scuba diving, skydiving, rock climbing or any other hazardous activities?
  - k. in the past 5 years flown or plan to fly in the future, as a pilot or crew member?
  - l. in the past 5 years had his/her driver's license suspended or revoked?

**If you answer "yes" to any of the following questions (5-8), please provide details in Section D.**

- 5. To the best of your knowledge and belief, in the past 10 years, has any person proposed for insurance had any indication, diagnosis or treatment of:** Yes No
- a. blood or lymph disorders, including, but not limited to, anemia, lymphadenopathy or Chronic Fatigue Syndrome?
  - b. congenital disorder, birth defects or developmental disorders, including, but not limited to:  
    - Down's Syndrome  mental retardation  autism  cleft palate  club foot
    - congenital heart defects  other \_\_\_\_\_
  - c. the respiratory system, including:  
    - allergies  asthma  pneumonia  emphysema  bronchitis
    - shortness of breath  chronic cough  apnea  sinusitis  tuberculosis
    - cystic fibrosis  other \_\_\_\_\_
  - d. the circulatory system, including:  
    - heart disease  heart defect  heart condition  mitral valve prolapse
    - heart attack  chest pain  varicose veins  high blood pressure (hypertension)
    - phlebitis  murmur  aneurysm  elevated cholesterol or triglycerides
    - Raynaud's Disease  stroke, TIA  palpitations/irregular heartbeat
    - Raynaud's Phenomenon  other \_\_\_\_\_
  - e. the digestive system, including:  
    - ulcer  esophagus  colitis  hepatitis, jaundice, or cirrhosis
    - gall bladder  bowel  polyps  diverticulitis, diverticulosis
    - gastritis  stomach  rectum  disorder of pancreas, spleen, liver
    - hernia  intestinal disorder  hemorrhoids  other \_\_\_\_\_
  - f. the nervous system, including:  
    - epilepsy  seizure  headaches  Alzheimers  Parkinson's disease
    - dizziness  fainting spells  cerebral palsy  multiple sclerosis
    - convulsions  paralysis  dementia  other \_\_\_\_\_

(Continued)

- |  | <b>Yes</b>               | <b>No</b>                |
|--|--------------------------|--------------------------|
| g. a mental or nervous disorder, including: .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> anxiety <input type="checkbox"/> A.D.D./A.D.H.D. <input type="checkbox"/> eating disorder <input type="checkbox"/> learning/behavior disorder<br><input type="checkbox"/> psychiatric treatment or counseling <input type="checkbox"/> depression <input type="checkbox"/> psychosis<br><input type="checkbox"/> other _____  |                          |                          |
| h. the genitourinary system, including: .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> prostate <input type="checkbox"/> kidney disorder or stones <input type="checkbox"/> urinary incontinence<br><input type="checkbox"/> urinary tract infection <input type="checkbox"/> bladder <input type="checkbox"/> other _____   |                          |                          |
| i. the endocrine system, including: .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> diabetes <input type="checkbox"/> goiter <input type="checkbox"/> thyroid gland <input type="checkbox"/> high or low blood sugar<br><input type="checkbox"/> glandular disorder <input type="checkbox"/> pituitary disorder <input type="checkbox"/> other _____  |                          |                          |
| j. the musculoskeletal system, including: .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> arthritis <input type="checkbox"/> gout <input type="checkbox"/> TMJ/jaw problems <input type="checkbox"/> lupus erythematosus <input type="checkbox"/> rheumatism<br><input type="checkbox"/> subluxation <input type="checkbox"/> physical handicap <input type="checkbox"/> fibromyalgia <input type="checkbox"/> loss of limb <input type="checkbox"/> knees<br><input type="checkbox"/> the back, spine, or muscles <input type="checkbox"/> other _____ |                          |                          |
| k. cancer, tumors, cysts, growths or breast disorders? (Provide location, type and treatment received.) .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| l. skin disorder/problems, such as psoriasis, keratosis, warts, birthmarks, 2nd or 3rd degree burns, or acne? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| m. the eyes, ears, nose, or throat, such as cataracts, glaucoma, speech or hearing impairment, otitis media or ear tubes? .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| n. any disease or disorder of female/male reproductive systems or genitalia, including: .....  | <input type="checkbox"/> | <input type="checkbox"/> |
| <input type="checkbox"/> ovaries <input type="checkbox"/> impotency <input type="checkbox"/> reproductive organ <input type="checkbox"/> irregular menstruation<br><input type="checkbox"/> infertility <input type="checkbox"/> uterus/cervix <input type="checkbox"/> premenstrual syndrome (PMS)<br><input type="checkbox"/> sexually transmitted disease <input type="checkbox"/> other _____  |                          |                          |

**6. Questions for female applicants only.**

- |  |                          |                          |
|--|--------------------------|--------------------------|
| a. Any complications of pregnancy, including, but not limited to, caesarean section delivery or miscarriage? .....                   | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Date of last pap smear _____ Results _____<br>Dr. Name & Address _____  |                          |                          |
| c. Have you been instructed to have a repeat pap smear or any follow-up treatment or tests as a result of your last pap smear? ..... | <input type="checkbox"/> | <input type="checkbox"/> |

7. In the past 10 years, has any person proposed for insurance consulted, been treated or examined by a physician, chiropractor, or other practitioner for any reason other than disclosed above? .....
8. To the best of your knowledge and belief, does any person to be insured have any mental or physical impairment, handicap, retardation, disease, disorder or deformity? .....

**D. Health Statement Details**

List complete details with respect to questions 4 thru 8. If additional space is needed, please use Section F for additional remarks.

Ques. No.	Person's Name	Dates of Treatment	Drugs & Dosage Prescribed, if any	Illness or Condition Treated	Remaining Effects (if none, list none.)	Complete Name, Address & Phone Number of Chiropractors, Physicians and Hospitals

(Continued)

Ques. No.	Person's Name	Dates of Treatment	Drugs & Dosage Prescribed, if any	Illness or Condition Treated	Remaining Effects (if none, list none.)	Complete Name, Address & Phone Number of Chiropractors, Physicians and Hospitals

**E. Medications**

1. Within the past 3 years, has any person proposed for insurance taken any prescription, alternative, complementary, herbal or natural medications other than noted in Section D? (If "yes", describe below) ..... Yes  No
2. Within the past 1 year, has any person proposed for insurance taken any supplements, or over-the-counter medications for a period longer than 5 consecutive days? (If 'yes', describe below) ..... Yes  No

Ques. No.	Name of Person	Name of Medication	Dosage & Frequency of Medication	Illness or Condition Treated	Date Last Taken	Name & Address of Physician

**F. Additional Remarks**

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**G. Verification of Information**

**By signing below:**

1. I represent that, to the best of my knowledge and belief, all answers are accurate, complete and true. I understand that World Insurance Company is relying on my answers in deciding whether to approve this application and that full and complete disclosure of the requested health information must occur for insurance to go into effect and that if I omit any of the requested health information, no insurance will go into effect for myself or my dependents. I understand the agent has no authority to alter or waive this, or any other condition of coverage.

I have not disclosed to the agent any health information which is not disclosed on this application. I understand that this application, if accepted, shall become a part of the certificate(s) and any incomplete, incorrect or misleading answers may be used to void any insurance provided to me and my dependents.  
 I understand that I (or the individual purchasing insurance for child-only coverage) must be an active, dues-paying member of the Association and that I and my spouse must both be between the ages of 16 and 64 to apply for insurance.  
 I understand precertification of certain outpatient procedures

and tests, as well as preadmission certification of all hospital admissions (emergency and non-emergency) is required. Any benefits which may be payable will be reduced according to the terms of the certificate, if precertification is not received.

2. I understand no insurance exists unless and until a certificate is delivered by World Insurance Company and accepted by me indicating coverage for myself and my dependents and the effective date, and that Association dues are required to purchase and continue insurance. If at any time prior to such notification, any person applying for coverage consults a physician, is hospitalized or has any change in health, I agree to inform World Insurance Company immediately. I understand that the agent does not have the authority to vary or waive any of the provisions of this application, nor any of the provisions, terms or conditions of any other forms or materials supplied by World Insurance Company nor to bind World Insurance Company to any promise of coverage.

I, the undersigned, understand that World Insurance Company will confirm the information on my application for insurance with a verification telephone call. It is my understanding that this verification call is a routine process for those applying for coverage. (Please Note: this telephone call will be recorded.) I also understand that my application will not be considered if verification is not completed. I understand that I must tell World Insurance Company if my health or if the health of any of my dependents changes between the date this application is signed and the date I receive written notification of approval, providing coverage is approved by World Insurance Company.

3. I acknowledge that:

- a. I understand that the opportunity to apply for group insurance is contingent upon membership in the association (this application cannot be used to apply for membership in the association; a separate application must be submitted); and
- b. I certify that the following information is correct and true as it relates to the health insurance being applied for:
  - (1) no portion of the premium will be paid, during the period the certificate is in force, by or on behalf of my employer, either directly, or through wage adjustments or other means of reimbursement;
  - (2) neither I, nor my spouse, nor my dependents, nor my employer intends to treat the certificate, during the period the certificate is in force, as part of a plan or program under Section 162 (other than Section 162(1)), Section 125, or Section 106 of the United States Internal Revenue Code.
- c. I have read this application and the brochure and I understand and accept the terms and conditions provided in all these

materials including, but not limited to, the certificate benefits, exclusions and limitations.

- d. Any disputes arising under the certificate are subject to an appeals procedure.
- e. When applying for child-only coverage, I also understand and agree that:
  - (1) the member is the person who will receive all correspondence and communications from World Insurance Company regarding this child-only coverage.
  - (2) the member is the individual who is purchasing coverage for the proposed insured under the child plan.
  - (3) the member is responsible for paying all premiums when due.
- f. Please Note: It is a crime to knowingly provide false, incomplete or misleading information to an insurance company for the purpose of defrauding the company. Penalties include imprisonment, fines and denial of insurance benefits.
- g. Authorization to obtain Information:

I understand World Insurance Company or its reinsurers will gather information regarding me or my family. This information may include the Medical Information Bureau; employer(s); consumer reporting agency; or the Veterans Administration.

I UNDERSTAND the information obtained by use of this Authorization will be used by World Insurance Company to determine eligibility for insurance or benefit determination. Any information obtained will not be released by World Insurance Company to any person or organization EXCEPT to reinsuring companies, the Medical Information Bureau, Inc., or other persons or organizations performing business or legal services in connection with my application, or as may be otherwise lawfully required or as I may further authorize.

I know I have the right to make a written request within a reasonable time to receive additional, detailed information about the nature and scope of this investigation. I understand that this information will be used by World Insurance Company to determine eligibility for insurance, certificate reinstatement or a change of benefits. I agree this authorization is valid for twenty-four (24) months from the date signed. I know I or my authorized representative has the right to receive a copy of this authorization upon request. I agree that a photographic copy of this authorization is as valid as the original.

I, the undersigned represent to the best of my knowledge and belief, that all statements contained herein are complete and true. Under the penalties of perjury, I certify that the Social Security Number(s) provided are true, correct and complete.

Application dated at (City, State) \_\_\_\_\_

Signature of Member \_\_\_\_\_ Date Signed \_\_\_\_\_

Signature of Spouse (if applying for coverage) \_\_\_\_\_ Date Signed \_\_\_\_\_

Signature of Member (if other than Parent or Legal Guardian) for child-only coverage \_\_\_\_\_ Date Signed \_\_\_\_\_

Signature of Parent or Legal Guardian (if other than Member) for child-only coverage \_\_\_\_\_ Date Signed \_\_\_\_\_

Signature of Agent \_\_\_\_\_ Agent Code \_\_\_\_\_ Date Signed \_\_\_\_\_

Printed Name of Agent \_\_\_\_\_







## Application for NCA Membership

I am applying for membership in the National Consumer Alliance Association (NCA). I represent that I am eligible for membership in NCA. My dues will be \$7.50 a month, or \$90 annually.

I also will be able to apply for health insurance with World Insurance through my membership with NCA. If my application for insurance is approved, I will be issued a policy/certificate of health insurance from World.

**I am applying for:**

**NCA membership and World health insurance**

**NCA membership only**

Date of Application \_\_\_\_\_

Date of Birth \_\_\_\_\_

Name \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ ZIP \_\_\_\_\_

Phone \_\_\_\_\_ E-mail \_\_\_\_\_

Signature \_\_\_\_\_

Please give this completed form and membership fee to your insurance agent, who will forward it along with your World health insurance application. If you're not applying for health insurance, your agent will forward the membership form and fee alone.

# NCA

**National Consumer Alliance Association**

## THE WORLD FOR LESS

Your  
NCA  
Membership  
Benefits

## Health Insurance You Can Afford

As an NCA member, you'll be eligible to apply for health insurance with World Insurance Company.

Our health insurance is developed specifically for NCA members and families seeking quality health insurance at an affordable price.

To help you match coverage to your needs, World offers a variety of plan options..

World insurance is fully underwritten and acceptance is based on individual health history, which helps to keep premium rates affordable.

For more information about this quality health insurance for NCA members, please ask your agent for a product brochure and premium quote.

## Discover Your Discounts

Eligibility to apply for World health insurance is just one NCA membership benefit. You're also entitled to these valuable NCA discounts:

➡ **Healthy Options** – When shopping for new glasses, NCA members receive a **20%** discount on purchases, as well as a **10%** discount on eye exams and contact lenses at some LensCrafters outlets. Additional retail eyewear discounts, up to **50%**, are available for frames, single vision lenses, and bifocals at thousands of provider locations.

But the savings aren't limited to vision. There's also discounts of up to **60%** for quality hearing aids, and discounts on dental care expenses through more than **24,000** providers. NCA members don't have to deal with complicated claim forms, maximums or deductibles.

A variety of vitamin and nutritional supplements carry a **15%** discount, savings of up to **30%** can be realized for complementary and alternative medicinal services, such as acupuncture, massage therapy and nutritional counseling.

And if you just have a health-related question, you can call **24-hour Nurse Line**. This service provides unlimited access to registered nurses, via a toll-free number, 24 hours a day, 365 days a year.

➡ **Mobile Alternatives** – For your next trip, you'll find special savings when you rent from Alamo, Hertz, Avis or National car rental agencies.

➡ **Entertaining Ideas** – NCA membership makes family vacations and weekend getaways even better with savings of **50% on accommodations** at more than 3,100 hotels, motels, inns and resorts. You also have access to discounts on business and leisure travel, which includes cruises and motorcoach tours.

➡ **Business Choices** – Your business's bottom line will become even brighter when you save up to **36% on already discounted prices** on a large selection of office supplies. And if you happen to need financing assistance with office equipment, rebates and discounts are available through Lease Now, Inc.

For employment security, background reports and investigation services are available at discounted rates through an internationally renowned investigative and consulting company.

➡ **Insurance** – Another plus of NCA membership is **\$2,000** in accidental death and dismemberment insurance through a national provider. It's a benefit that provides additional security and savings to NCA members.

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### About NCA

Established in 1987, the National Consumer Alliance Association gives members access to high-quality products and services at reasonable prices. NCA is based in Chesterfield, Mo.

### About World Insurance Company

World has provided affordable health insurance to individuals and families since 1903. The company is based in Omaha, Neb. In addition to World individual health insurance, World offers short-term medical and dental insurance.

*Your NCA membership kit will contain complete details on the discounted products and services available to you as a member. Taking advantage of these discounts will be as easy as showing your NCA card or providing your member number!*

# NCA

National Consumer Alliance Association

**NOTICE TO PROPOSED INSURED**

Thank you for your application for insurance.

We are required by Public Law 91-508, the Fair Credit Reporting Act and Privacy Act Prenotification, to inform you that as part of our underwriting procedure, an investigative consumer report may be obtained that will provide applicable information concerning character, general reputation, personal characteristics and mode of living.

Further information on the nature and scope of such report, if one is made, is available to you upon written request to the Underwriting Department at the above address.

Information given in your application may be made available to other insurance companies to which you make application for life or health insurance coverage or to which a claim is submitted.

**NOTIFICATION REGARDING THE MEDICAL INFORMATION BUREAU**

Information you provide will be treated as confidential except that World Insurance Company or its reinsurers may make a brief report thereon to the Medical Information Bureau, a nonprofit membership organization of life insurance companies that operates an information exchange on behalf of its members. Upon request by another member insurance company to which you have applied for life or health insurance coverage or to which a claim is submitted, the M.I.B will supply such company with the information it may have in its files.

Upon receipt of the request from you, the Bureau will arrange disclosure of any information it may have in your file. If you question the accuracy of information in the Bureau's file, you may contact the Bureau and seek a correction in accordance with the procedures set forth in the Federal Fair Credit Reporting Act. The address of the Bureau's information office is P.O. Box 105, Essex Station, Boston, MA 02112, telephone number (617) 426-3660.

World Insurance Company or its reinsurers also may release information in its files to other life insurance companies to which you may apply for life and health insurance, or to which a claim for benefits may be submitted.

**ABBREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES**

To issue a certificate, we need to obtain information about you and any other person proposed for insurance. Some of that information will come from you, and some will come from other sources. That information and any subsequent information collected by us may in certain circumstances be disclosed to third parties without your specific authorization.

You have the right of access and correction with respect to the information collected about you except information that relates to a claim or civil or criminal proceeding.

If you wish to have a more detailed explanation of our information practices, please contact World Insurance Company, P.O. Box 3160, Omaha, NE 68103-0160.

**CONDITIONAL RECEIPT**

**INSTRUCTIONS:** Complete Conditional Receipt ONLY when full premium, including all application fees, is being submitted with the application. Applicant is to sign the receipt. Agent is to witness signature and date the receipt. If premium is not being submitted, this receipt must remain attached to the application.

Received from \_\_\_\_\_ the sum of \$ \_\_\_\_\_ paid with the attached insurance application to World Insurance Company.

*Conditions* – World Insurance Company agrees to insure those proposed for insurance if:

1. The payment received with the application is equal to the full first modal premium, including all application fees, for this certificate,
2. All medical or lab tests, if required, have been completed and no adverse medical condition(s) have been detected which would result in the declination or amendment of the certificate; and
3. All those proposed for insurance are insurable on the date of application without special exception and at standard or preferred rates under the Company's regular underwriting rules and practices for the certificate applied for.

*Terms of Conditional Insurance:*

1. This conditional receipt is governed by the terms of the certificate applied for.
2. This conditional receipt terminates 45 days after the application date, when the certificate applied for is declined or withdrawn, or when the certificate applied for becomes effective, whichever occurs first. The effective date will be the earlier of a) underwriting approval date or b) specified future effective date (no sooner than 10 days after application date).

**No Representative of the Company is authorized to modify this Conditional Receipt**

Signature of Applicant \_\_\_\_\_ Signature of Agent/Broker \_\_\_\_\_

Date \_\_\_\_\_ Agent # \_\_\_\_\_

**PERSONAL PROFILE INTERVIEW**

Please call 800-846-9981 for your Personal Profile Interview. The hours available to complete your Interview are Monday thru Friday 7 a.m. to 9 p.m. and Saturday 9 a.m. to 3 p.m.

*Make checks payable to World Insurance Company*

Application Fees are non-refundable unless required by state law.

# Completing Your Personal Profile Interview

**T**hank you for choosing World Insurance Company to provide insurance protection for you and your family. As part of World's process for issuing your coverage, every adult applying for coverage will be asked to participate in a telephone interview to complete a personal profile of information important to the application process.

## How To Complete Your Personal Profile Interview

*Use the space below to capture information for ready reference.*

1. Gather the names, addresses and phone numbers of all health care providers (physicians, specialists, chiropractors, etc.) you or any applicants for coverage have consulted in the past 10 years. Please include information about hospitals, outpatient surgical facilities and medical tests.
2. Gather information about the medications you or any applicant are currently taking or have taken in the past.
3. Select a convenient time to call and a private location, as some of the questions will explore the details of your health history. Please set aside approximately 20-30 minutes for the interview. All adults applying for coverage will need to be available to be interviewed.
4. Call 800-846-9981, Monday through Friday between 7 a.m. and 9 p.m., Central Standard Time, or Saturday, between 9 a.m. and 3 p.m. to complete your Personal Profile Interview.

## Personal Information

Please use this space to record your healthcare provider information and your medical history for your personal interview.

### Healthcare Providers

Name	Address	Phone	Dates Visited/Reason

### Medications – Past and Present

Name	Dosage and Frequency	Dates Taken





P.O. Box 3160  
Omaha, NE 68103-0160  
(402) 496-8000

## Notice of Privacy Policy and Insurance Information Practices

**Your privacy is important to us.** This notice is being provided to you pursuant to the requirements of federal and state laws and/or regulations addressing the privacy of nonpublic personal consumer information, which may include financial and health information. This notice details the privacy policy and insurance information practices of World Insurance Company, as it relates to your nonpublic personal information.

**Information Collected** – We may collect nonpublic personal information about you to provide and administer products and services. We collect information about you from a variety of sources, such as:

- Information we receive from you or through our affiliates or subsidiaries, producers or other individuals, on applications, forms or interviews, such as salary information or health history. We may also collect identifying information such as name, address, social security number and age.
- Information about your transactions with us, our affiliates, or others, such as information about insurance premium payments, coverage selections, and claims history.
- Information received from a third party or consumer reporting agency, such as creditworthiness and credit history, or motor vehicle driving record report.
- Information received from medical providers regarding treatment of health conditions and payment for that treatment.

**Disclosure Policy** – We may disclose the personal information we collect to service, process or administer business operations, as permitted by law. Examples of how we may disclose your information are as follows:

- To process your applications and issue your coverage.
- To pay your claims.
- To provide service, perform policy maintenance or make any coverage changes you may request.
- To offer products or services that may be of interest to you.

We may disclose relevant portions of the information we collect, as described above, to companies that perform services on our behalf or with whom we have joint marketing agreements. The agreements prohibit the third party from disclosing or using the information other than to carry out the function on our behalf for which the information was collected or disclosed.

We will not, however, disclose your health information for marketing purposes.

**Financial information** – We do not disclose nonpublic personal financial information about you to nonaffiliated third parties, except as permitted or required by law.

**Health Information** – We do not disclose nonpublic personal health information, other than as permitted or required by law, unless you specifically authorize us in writing in advance to release such information.

**Fair Credit Reporting Act** – We do not disclose information subject to the Fair Credit Reporting Act except as permitted or required by law.

**Confidentiality and Security** – We restrict access to nonpublic personal information about you to those employees who need to know that information for a business purpose in order to provide products and services to you. We maintain physical, electronic, and procedural safeguards that comply with requirements to protect your nonpublic personal information. Additionally, we maintain policies about the proper physical security of workplaces and records.

**Former Customers** – We do not disclose nonpublic personal information about former customers except as permitted or required by law.

**If you have any questions regarding this notice, please contact us at World Insurance Company, (800) 786-7557.**

We reserve the right to change the privacy practices of World Insurance Company. If we do so, we will communicate any material changes to you as required by law.

This notice applies to all prospects, applicants, customers and former customers who have inquired about or purchased insurance products used primarily for personal, family or household purposes.



P.O. Box 3160  
Omaha, NE 68103-0160  
(402) 496-8000

## Notice of Privacy Practices – Medical

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU  
MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY.

**You have a right to know how your medical information is used and shared by us. PLEASE READ THIS NOTICE.** It explains how we use information about you and when we can share that information with others. This Notice applies to current and former insureds, as well as covered dependents. Whenever we use the word “you” and “your”, it applies to everyone covered under your policy/certificate.

*Protected Health Information (“PHI”)* means information that is about you or identifies you. It includes demographic information, as well as information about your past, present or future physical or mental health or condition, the provision of your health care or the past, present or future payment of your health care. It does not include employment records or educational records covered by the Family Educational rights and Privacy Act.

We are legally required to keep your PHI confidential and private. We must also provide you with this notice which explains our legal duties and privacy practices and abide by it. We reserve the right to change our privacy practices which will apply to all PHI we maintain. If we make material changes to our privacy practices, we will provide you a copy of our revised Notice of Privacy Practices. At least every three years, we will let you know how you can access our Notice of Privacy Practices. If two or more insureds are named on your insurance contract, we will send only one notice to the insureds.

**Confidentiality and Security** – We view the security of your confidential and private information as a top priority and we strive to maintain appropriate physical, electronic and procedural safeguards to protect it. Only employees who need your information to perform their jobs can access your information. Additionally, we train our work force on protecting your PHI.

**USES AND DISCLOSURES OF PHI** – We do not use or share your PHI without your valid authorization unless permitted or required by law. Your authorization must be in writing and we have a form available for your use. You may contact our Customer Service Department at the address listed at the bottom of this notice to obtain a valid authorization form.

Subject to state and federal laws, we are required or permitted to use and/or share your PHI without your authorization in certain circumstances, such as:

- To you, the subject of the PHI.

- To the U.S. Department of Health and Human Services for purposes of compliance with federal privacy rules.
- For your treatment, payment and/or health care operations. Examples of sharing for **treatment** purposes may be to provide a doctor or healthcare facility involved in your care information they request to assist in your care. Examples of **payment** purposes may be to collect premiums, determine eligibility for coverage, subrogation, billing activities, claims management, or disclosure to consumer reporting agencies. Examples of **health care operations** might include general administrative and business functions necessary for us to perform business such as underwriting, premium rating and other activities needed to issue, renew or replace an insurance policy/certificate.
- Persons assisting in your care and/or payment for care. If you are available and do not object, we may share your information with a family member, friend or someone involved with your care or payment for care. If you are unavailable, incapacitated, or involved in an emergency situation, and we determine that a limited disclosure is in your best interest, we may share limited information without your approval.
- Required by law. We may use and/or share your information to the extent required to comply with the law.
- Public health activities. We may share your PHI with a public health authority that collects or receives information such as required reporting of disease, injury, birth or death and for required public health investigations.
- Reporting about victims of abuse, neglect or domestic violence. We may share PHI with a public health authority, governmental entity or agency if we suspect child abuse or neglect, or if we believe you to be a victim of abuse, neglect or domestic violence.
- Health oversight activities. We may use and/or share PHI for audits, investigations and inspections to government agencies that oversee the healthcare system, government programs, and civil rights laws.
- Judicial and administrative proceedings. We may use and/or share your PHI in the course of a judicial or administrative proceeding, order or a court or administrative tribunal and in response to a subpoena, discovery request or other lawful purposes.
- Law enforcement purposes. We may use and/or share your PHI for (1) lawful processes and otherwise required by law; (2) concerning crime victims; (3) suspicious deaths; (4) crimes on our premises; (5) reporting crimes in

***Please leave with Proposed Insured in all cases***

emergencies; and (6) for the purposes of identifying or locating a suspect or other person.

- Information about decedents. We may use and/or share PHI with coroners and medical examiners to identify a deceased person, determine a cause of death, or as authorized by law. We may use and/or share PHI with funeral directors as necessary to carry out their duties.
- Organ, eye or tissue donation purposes. We may use and/or share PHI with organ procurement organizations or other entities associated with the banking or transplantation of organs, eyes or tissues.
- Avert a serious threat to health or safety. We may use and/or share PHI to prevent or lessen a serious and imminent threat to the health or safety of you or the public.
- Specialized government functions. We may use and/or share PHI for military and veteran activities, national security and intelligence activities, protective services to the President or other authorized persons.
- Workers' compensation. We may use and/or share PHI as necessary to comply with workers' compensation laws.

**OTHER LAWS** – If there is a law applicable to you that provides greater protection or greater rights regarding your PHI, we will comply with that law.

**OTHER DISCLOSURES** – We may disclose PHI to our business associates who help us conduct our business. They may not use or reuse your PHI except for providing the services we have contracted with them to perform on our behalf. Our business associates are also contractually obligated to maintain appropriate safeguards to protect PHI. Also, we may communicate directly with you about contract benefits or other covered products to enhance your current benefits.

Other disclosures require your valid authorization. Specific authorizations may be required for the release of psychotherapy notes and marketing with certain exceptions. You may revoke in writing any authorization you provide us.

**YOUR RIGHTS**

- You have the **right to request restrictions** on the use and disclosure of PHI in writing to carry out your treatment, payment or health care operations. **WE ARE NOT REQUIRED TO AGREE TO YOUR REQUEST.** Restriction forms can be obtained from our Customer Service Department at the address listed below.
- You have the **right to request confidential communications** from us by alternative means or at alternative locations. This request must be in writing. We will accommodate reasonable requests. Confidential Communication forms can be obtained from our Customer Service Department at the address listed below.
- You have the **right to inspect and copy your PHI** we maintain about you in our designated record set, with some exceptions, as defined by law. All requests must be made in writing and signed by you or your personal representative. Access request forms are available from our Customer Service Department at the address listed below.

- You have the **right to request an amendment** to certain components of your PHI to correct inaccuracies. We are not obligated to make all requested amendments, but will give each request careful consideration. All amendment requests must be in writing, signed by you or your personal representative, and must state the reasons for the requested amendment. Amendment request forms can be obtained from our Customer Service Department at the address listed below.
- You have the **right to receive an accounting of certain disclosures** made by us after April 14, 2003 of your personal health information. Please note that we are not required to provide you with an accounting of the information that was collected prior to April 14, 2003; used or disclosed for treatment, payment, and/or healthcare operations; disclosed to you or pursuant to your authorization; incidental to a use or disclosure otherwise permitted by law; disclosed for a facility's directory or to a person involved in your care or other notification purposes; disclosed for national security or intelligence purposes; disclosed to correctional institutions, law enforcement officials or health oversight agencies; used or disclosed as part of a limited data set for research, public health or health care purposes.

Your request must be made in writing and you can obtain an accounting request form from our Customer Service Department at the address listed below. The first accounting in any 12-month period is free of charge; however, a fee will be charged for any subsequent request for an accounting during that same time period.

- You have the **right to obtain a copy of this notice** upon request at any time. We are required to abide by the terms of this notice. We reserve the right to change our privacy practices and the terms of this notice at any time and to make the new notice effective for all protected health information we maintain. If we do revise this notice, a copy will be sent to you at the time of the change.

**COMPLAINTS** – You may file a written complaint if you believe your privacy rights have been violated by submitting your complaint to our Customer Service Department at the address listed below. You may also file your complaint directly to the Secretary of the U.S. Department of Health and Human Services. If you file a complaint, we will not retaliate against you for that action.

**CONTACT INFORMATION** – If you have any questions regarding this notice, please contact us at:  
World Insurance Company  
P.O. Box 3160  
Omaha, NE 68103-0160  
800-786-7557 (Monday through Friday 7:30 a.m. to 5:00 p.m., Central Time)

**EFFECTIVE DATE** – This notice is effective as of April 14, 2003 and thereafter until amended or revised by us.