



Application to World Insurance Company
(herein called the Company) for Health Coverage
P.O. Box 3160 • Omaha, NE 68103-0160

To be completed by Agent
Agent #

Complete & Submit
Home Office Use Only
Application #

A. General Information (please print)

1. Your Information

Name (First, Middle, Last) _____
 Address (Street, City, State, ZIP) _____
 Home Phone Number _____ Cell Phone Number _____
 Best Time to Call: AM PM Home Work Cell
 Email Address (It may be used to send you important notices.) _____
 Employer (Name, Street, City, State, ZIP) _____
 Occupation/Duties _____ Work Phone Number _____
 If unemployed or employed part-time, are you seeking full-time employment? Yes No
 Driver's License Number/State _____

2. Your Spouse's Information (where different)

Name (First, Middle, Last) _____
 Address (Street, City, State, ZIP) _____
 Home Phone Number _____ Cell Phone Number _____
 Best Time to Call: AM PM Home Work Cell
 Email Address (It may be used to send you important notices.) _____
 Employer (Name, Street, City, State, ZIP) _____
 Occupation/Duties _____ Work Phone Number _____
 If unemployed or employed part-time, are you seeking full-time employment? Yes No
 Driver's License Number/State _____

3. Persons proposed for insurance. List first, MI, and last names.	Birthdate Mo./Day/Yr.	State of Birth	Ht. ft., in.	Wt. lbs.	Sex	Full-time Student	Social Security Number
You					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Spouse					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	
Dependent					<input type="checkbox"/> M <input type="checkbox"/> F	<input type="checkbox"/> Yes <input type="checkbox"/> No	

4. Residency Information

- a. Do all people requesting coverage live in the same household?..... Yes No
 b. Are all of you U.S. citizens, have established permanent resident status, and have been in the U.S. a minimum of two years? ... Yes No
 If "No" to a. or b., explain: _____
 c. Are any of you planning to live, work or attend school outside the U.S. for more than 60 consecutive days?..... Yes No
 If "Yes" to c., explain: _____

5. Please complete if Life Benefit selected:

Beneficiary (First, Middle Initial, Last)	Address (Street, City, State, ZIP Code)	Social Security Number	Relationship
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B. HIPAA Eligible Individual Determination

You may be eligible for guaranteed issue health coverage if you qualify under the rules of the Health Insurance Portability and Accountability Act (HIPAA). The information you provide in this section will help determine whether you qualify under HIPAA. Please answer the following questions for all applicants.

- Was there any period of 63 days or more during the past 18 months when you were not continuously covered by group or individual health insurance, Medicare, Medicaid or any other health insurance?..... Yes No
- If you answered "Yes" to question 1, were you offered coverage under COBRA or a similar state program, and
 - refused coverage? Yes No
 - were not covered through COBRA for the full allowable period of coverage available?..... Yes No
 - are presently eligible for such coverage? Yes No
- Are you presently eligible for, or will you be eligible for health coverage provided by an employer? Yes No
- Was your most recent health insurance coverage terminated for non-payment of premium, misrepresentation or fraud?..... Yes No
- Do you currently have health insurance in force? Yes No
- Was your most recent health insurance coverage through an employer-sponsored group plan?..... Yes No

If you answered "No" to questions 1-5, and "Yes" to question 6, you meet the definition of an Eligible Individual.
 I elect to apply as a HIPAA Eligible Individual and understand the rates for this plan will be substantially higher than underwritten-plan rates.
 I am a HIPAA Eligible Individual, but elect to be underwritten and waive any available rights as an Eligible Individual. I understand I will be subject to pre-existing condition exclusions.

C. General Medical Overview

1. **Within the past 5 years**, have you or any applicant been treated for, been diagnosed as having, or had symptoms of any of the following medical conditions?
 - a. Heart attack, angina, congestive heart failure, heart surgery, bypass or angioplasty? Yes No
 - b. Rheumatoid arthritis, connective tissue disorders or psoriatic arthritis? Yes No
 - c. Addison's Disease, Cushing's Syndrome or pheochromocytoma (tumor of the adrenal gland)? Yes No
 - d. Diabetes, including hyperglycemia, insulin resistance or impaired glucose tolerance? Yes No
 - e. Inflammatory bowel disease including ulcerative colitis or Crohn's disease? Yes No
 - f. Chronic obstructive pulmonary disease (COPD) requiring oxygen, emphysema requiring oxygen or cystic fibrosis? Yes No
 - g. Schizophrenia, psychoses, Alzheimer's disease or dementias? Yes No
 - h. Stroke/TIA, Parkinson's disease? Yes No
 - i. Liver failure, kidney failure/dialysis? Yes No
 - j. Amyotrophic lateral sclerosis (ALS), multiple sclerosis (MS), muscular dystrophy (MD) or lupus (systemic)? Yes No
 - k. Major organ transplant, including heart, lung, kidney or liver? Yes No
 - l. Cancer including, but not limited to, cancer of any organ, melanoma, sarcoma, leukemia, Hodgkin's or other lymphoma, but excluding basal or squamous cell skin cancers? Yes No
 2. Are any of you now pregnant, an expectant father, in the process of adopting a child, or planning to serve as a surrogate? Yes No
 3. Are any of you eligible for Medicare due to a disability? Yes No
 4. Within the past 10 years,
 - a. Have you or any applicant ever been positively diagnosed as having, or been treated by a member of the medical profession as having AIDS (acquired immune deficiency syndrome), ARC (AIDS-related complex), or any other disease or disorder of the immune system? Yes No
 - b. Have you or any applicant ever tested positive for AIDS/HIV (limited to FDA licensed tests)? Yes No
- To be answered if proposed insured is a resident of the State of Florida.**
2. Have you or any applicant been tested positive for exposure to HIV (Human Immunodeficiency Virus Infection) or been diagnosed as having ARC (Aids-Related Complex) or AIDS (Acquired Immune Deficiency Syndrome) caused by the HIV infection or other sickness or condition derived from such infection? Yes No

Note: Applicant(s) who answers "Yes" to any questions in this section is not eligible for coverage. Please indicate individual(s):

D. Comprehensive Medical and Additional History

Please indicate "YES" or "NO" for each category. If you answer "YES", check (✓) the applicable condition and provide details in the space provided in the Explanation of Health Section. Categories do not necessarily include all the conditions related to that category, so please indicate "Other" for any conditions not listed.

Within the last 10 years, have you or any applicant been treated for, diagnosed with or had symptoms of any of the following:

1. **Ears/Eyes/Nose/Throat** Yes No

<input type="checkbox"/> Ear infections/otitis	<input type="checkbox"/> Otosclerosis	<input type="checkbox"/> Double vision	<input type="checkbox"/> Retinal detachment
<input type="checkbox"/> Hearing loss	<input type="checkbox"/> Cochlear implant	<input type="checkbox"/> Loss of vision	<input type="checkbox"/> Rhinitis
<input type="checkbox"/> Meniere's disease	<input type="checkbox"/> Strabismus/lazy eye	<input type="checkbox"/> Macular degeneration	<input type="checkbox"/> Optic Neuritis
<input type="checkbox"/> Ear tubes	<input type="checkbox"/> Cataracts	<input type="checkbox"/> Glaucoma/Increased eye pressure	<input type="checkbox"/> Sinusitis
<input type="checkbox"/> Enlarged tonsils/Adenoids	<input type="checkbox"/> Tonsillitis		<input type="checkbox"/> Other _____
2. **Lungs and Respiratory** Yes No

<input type="checkbox"/> Allergic rhinitis	<input type="checkbox"/> Reactive airway disease	<input type="checkbox"/> Chronic lung disease	<input type="checkbox"/> Chronic obstructive pulmonary disease
<input type="checkbox"/> Allergic sinusitis	<input type="checkbox"/> Bronchitis	<input type="checkbox"/> Tuberculosis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Asthma	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> Sleep apnea	
<input type="checkbox"/> Emphysema	<input type="checkbox"/> Chronic cough		
3. **Heart/Circulatory** Yes No

<input type="checkbox"/> Chest pain	<input type="checkbox"/> Heart surgery (stent placement, coronary artery bypass, angioplasty, valve)	<input type="checkbox"/> High blood pressure/hypertension	<input type="checkbox"/> Claudication
<input type="checkbox"/> Heart valve disorders	<input type="checkbox"/> Heart murmurs	<input type="checkbox"/> Phlebitis	<input type="checkbox"/> High lipid (cholesterol or triglycerides)
<input type="checkbox"/> Coronary artery disease	<input type="checkbox"/> Peripheral vascular disease	<input type="checkbox"/> Thrombophlebitis	<input type="checkbox"/> Other _____
<input type="checkbox"/> Angina	<input type="checkbox"/> Edema	<input type="checkbox"/> Varicose veins	
<input type="checkbox"/> Heart attack		<input type="checkbox"/> Aneurysm	
<input type="checkbox"/> Irregular heart beat			
4. **Blood/Lymph/Anemia** Yes No

<input type="checkbox"/> Anemia	<input type="checkbox"/> Thrombocytopenia	<input type="checkbox"/> Bleeding disorders	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hemophilia	<input type="checkbox"/> Hyperglycemia (high blood sugar)		
5. **Digestive** Yes No

<input type="checkbox"/> Esophagitis	<input type="checkbox"/> Ulcers	<input type="checkbox"/> Ulcerative colitis	<input type="checkbox"/> Rectal bleeding
<input type="checkbox"/> Gastric reflux/GERD	<input type="checkbox"/> Gastritis	<input type="checkbox"/> Crohn's disease	<input type="checkbox"/> Other _____
<input type="checkbox"/> Hernia	<input type="checkbox"/> Recurrent indigestion	<input type="checkbox"/> Hemorrhoids	
<input type="checkbox"/> Irritable bowel	<input type="checkbox"/> Diverticulosis	<input type="checkbox"/> Chronic diarrhea	

D. Comprehensive Medical and Additional History (Cont'd.)

6. Liver/Gallbladder/Pancreas				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Cirrhosis	<input type="checkbox"/> Fatty liver	<input type="checkbox"/> Pancreatitis	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Hepatitis	<input type="checkbox"/> Gallstones	<input type="checkbox"/> Spleen/pancreas disease		
7. Urologic/Kidney/Bladder				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Bladder infections	<input type="checkbox"/> Overactive bladder	<input type="checkbox"/> Interstitial cystitis	<input type="checkbox"/> Nephritis	
<input type="checkbox"/> Incontinence	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Pyelonephritis	<input type="checkbox"/> Other _____	
8. Reproductive/Breast				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Prostate disorder	<input type="checkbox"/> Ovarian disorders	<input type="checkbox"/> Cesarean section delivery	<input type="checkbox"/> Menstrual disorders	
<input type="checkbox"/> Impotence	<input type="checkbox"/> Infertility	<input type="checkbox"/> Breast cysts/lumps	(painful, excessive or	
<input type="checkbox"/> Abnormal Prostate Specific	<input type="checkbox"/> Sexually transmitted disease	<input type="checkbox"/> Abnormal mammogram	irregular bleeding	
Antigen (PSA)	<input type="checkbox"/> Complications of pregnancy	<input type="checkbox"/> Gynecomastia	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Abnormal PAP smear	<input type="checkbox"/> Human papillomavirus (HPV)	<input type="checkbox"/> Endometriosis		
<input type="checkbox"/> Uterine fibroids	<input type="checkbox"/> Mastitis			
9. Skin				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Acne/rosacea	<input type="checkbox"/> Eczema	<input type="checkbox"/> Shingles	<input type="checkbox"/> Keratosis	
<input type="checkbox"/> Hemangioma	<input type="checkbox"/> Psoriasis	<input type="checkbox"/> Herpes	<input type="checkbox"/> Other _____	
10. Bone/Muscular/Connective Tissue				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Arthritis	<input type="checkbox"/> Osteoarthritis	<input type="checkbox"/> Joint pain	<input type="checkbox"/> Sciatica	
<input type="checkbox"/> Gout	<input type="checkbox"/> Joint replacement	<input type="checkbox"/> Curvature subluxation	<input type="checkbox"/> Fracture(s)	
<input type="checkbox"/> Back/spine conditions	<input type="checkbox"/> Back pain	<input type="checkbox"/> Osteopenia/osteoporosis	<input type="checkbox"/> Fibromyalgia	
<input type="checkbox"/> Herniated, bulging or	<input type="checkbox"/> Scoliosis	<input type="checkbox"/> Rheumatoid arthritis	<input type="checkbox"/> Other _____	
degenerative discs	<input type="checkbox"/> Degenerative joint disease	<input type="checkbox"/> Muscular pain		
11. Prosthetic Devices/Plates, Pins, Screws				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Plates, pins, screws	<input type="checkbox"/> Artificial limb	<input type="checkbox"/> Shunts	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Rods	<input type="checkbox"/> Pacemakers	<input type="checkbox"/> Valve/joint replacement		
12. Nervous System				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Dizziness/syncope	<input type="checkbox"/> Restless leg syndrome	<input type="checkbox"/> Seizures	<input type="checkbox"/> Other _____	
<input type="checkbox"/> Cerebral palsy	<input type="checkbox"/> Carpal tunnel syndrome	<input type="checkbox"/> Epilepsy		
<input type="checkbox"/> Neuropathy	<input type="checkbox"/> Headaches/migraines	<input type="checkbox"/> Tourette's syndrome		
<input type="checkbox"/> Muscular weakness	<input type="checkbox"/> Paralysis	<input type="checkbox"/> Convulsions		
13. Endocrine/Thyroid				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Diabetes	<input type="checkbox"/> Hyperthyroid	<input type="checkbox"/> High blood sugar	<input type="checkbox"/> Impaired glucose tolerance	
<input type="checkbox"/> Goiter	<input type="checkbox"/> Hypothyroid	<input type="checkbox"/> Insulin resistance	<input type="checkbox"/> Other _____	
14. Cancer/Tumors				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Of internal organ	<input type="checkbox"/> Hodgkin's disease	<input type="checkbox"/> Adenoma	<input type="checkbox"/> Breast cancer	
<input type="checkbox"/> Leukemia	<input type="checkbox"/> Sarcoma	<input type="checkbox"/> Basal or squamous cell	<input type="checkbox"/> Neoplasm	
<input type="checkbox"/> Melanoma	<input type="checkbox"/> Other lymphoma	skin cancer	<input type="checkbox"/> Other _____	
15. Psychological				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Emotional disorder	<input type="checkbox"/> Attention deficit disorder	<input type="checkbox"/> Bipolar (manic depression)	<input type="checkbox"/> Obsessive compulsive	
<input type="checkbox"/> Anxiety	<input type="checkbox"/> Eating disorder	<input type="checkbox"/> Psychiatric treatment or	disorder	
<input type="checkbox"/> Depression	<input type="checkbox"/> Chemical imbalance	counseling	<input type="checkbox"/> Other _____	
16. Congenital Disorders/Birth Defects/Developmental Disorders				<input type="checkbox"/> Yes <input type="checkbox"/> No
<input type="checkbox"/> Down's syndrome	<input type="checkbox"/> Autism	<input type="checkbox"/> Cleft lip/palate	<input type="checkbox"/> Speech impairment	
<input type="checkbox"/> Mental retardation	<input type="checkbox"/> Club foot	<input type="checkbox"/> Delayed development	<input type="checkbox"/> Other _____	
17. Other Conditions				
a. In the past 10 years, have you or any applicant required an emergency room visit, hospital stay, surgery, or treatment?				<input type="checkbox"/> Yes <input type="checkbox"/> No
b. In the past 10 years, have you or any applicant been recommended to have surgery or to receive treatment from a physician, chiropractor or other practitioner?.....				<input type="checkbox"/> Yes <input type="checkbox"/> No
c. Do you or any applicant have any medical conditions/symptoms for which you have not seen a health care provider? ...				<input type="checkbox"/> Yes <input type="checkbox"/> No
d. Have you or any applicant had any tests or procedures recommended that have not yet been performed?.....				<input type="checkbox"/> Yes <input type="checkbox"/> No
18. Medication Use				
a. Have you or any applicant taken or been recommended to take any prescription medication in the last 2 years?				<input type="checkbox"/> Yes <input type="checkbox"/> No
b. In the last two years have you or any applicant taken any herbal or over-the-counter medication more often than once a week?				<input type="checkbox"/> Yes <input type="checkbox"/> No
19. Substance Abuse/Advice to Reduce or Eliminate Use				
a. In the past 5 years, have you or any applicant 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?.....				<input type="checkbox"/> Yes <input type="checkbox"/> No
b. In the past 5 years, have you or any applicant ever used non-prescribed sedatives, tranquilizers, cocaine, marijuana, hallucinogenic, other narcotic drugs or controlled substances, or received treatment or evaluation for drug abuse or chemical dependency?.....				<input type="checkbox"/> Yes <input type="checkbox"/> No
20. Tobacco Use				
In the past 12 months, has anyone used cigarettes, cigars, pipes, oral tobacco or nicotine replacements?				<input type="checkbox"/> Yes <input type="checkbox"/> No
If "YES", list name(s): _____				

D. Comprehensive Medical and Additional History (Cont'd.)

21. High Risk Activities

In the past 2 years, has anyone participated in hazardous activities, including activities like hang-gliding, scuba diving, rodeoing or racing (including automobile, motorcycle, etc.)? Yes No

If "YES", list name(s): _____
 Activity: _____ Frequency: _____

22. Driving Violations

In the past 2 years, has anyone been convicted of any driving violation, including DUI, DWI, license suspension or revocation, or 3 or more speeding violations? Yes No

Name: _____ Date: _____ Violation _____
 Name: _____ Date: _____ Violation _____

23. Complete ONLY if applying for Critical Illness/Cancer Care

Has any applicant's biological parents, brothers or sisters, either living or deceased, been diagnosed prior to age 55 with any of the following: diabetes, heart disease, stroke, kidney disease, internal cancer or MS, Alzheimer's, Parkinson's? Yes No

Name	Family member's relationship	Condition	Age at onset	Current age/ Age at death

Explanation of Health

Provide details for all questions 1 through 19 with "YES" answers. If you need additional space, please include a separate sheet and sign, date and attach to this application.

a. Name		Medical Condition	Date of Onset
Dates of Treatment	Treatment (prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)		
Physician's Name		Physician's Location (City/State)	Phone Number
b. Name		Medical Condition	Date of Onset
Dates of Treatment	Treatment (prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)		
Physician's Name		Physician's Location (City/State)	Phone Number
c. Name		Medical Condition	Date of Onset
Dates of Treatment	Treatment (prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)		
Physician's Name		Physician's Location (City/State)	Phone Number
d. Name		Medical Condition	Date of Onset
Dates of Treatment	Treatment (prescription drugs, herbal or over-the-counter medications, office visits, therapy, or surgery)		
Physician's Name		Physician's Location (City/State)	Phone Number

Physician Information

Name of Primary Physician	Location City/State	Phone Number	Date Last Seen	Reason for Visit	Results
Primary					
Spouse					
Dependent					
Dependent					
Dependent					
Dependent					

Please add any additional information you feel will be helpful in evaluating your application on a separate sheet and sign, date and attach to this application.

E. Other Coverage

1. Is any person applying for coverage covered by another plan? Yes No
 If "Yes", list name(s): _____
 If "Yes", check all that apply: COBRA Individual Medicare/Medicaid Other Coverage _____
2. Will the plan applied for replace the existing coverage(s)? Yes No
 Effective date of other coverage(s): _____
 Paid-to-date(s) or expected termination date(s) of their coverage(s): _____

 Name(s), certificate number(s) and telephone number(s) of other carrier(s): _____

Please Note: Other coverage should not be terminated until a new certificate is issued and accepted.

Please Read, Sign and Date

I have read and agree:

- **No insurance exists unless and until coverage is approved by the Company, the first premium is paid and a certificate is delivered.**
- The information furnished is complete, true and correctly recorded to the best of my knowledge.
- Any false statement or misrepresentation may result in loss or reduction of coverage or an increase in premium.
- *(Where applicable)* Association membership and dues may be required to purchase and continue this insurance.
- If requested, I will complete a recorded telephone call with a Company representative as part of the underwriting process.
- I must tell the Company if the health of any applicant changes prior to delivery of the certificate.
- The certificate, if issued, will cover accidents that occur and illnesses, the symptoms of which manifest after the date the certificate is issued.
- Health conditions present before the application is signed will be covered only if listed on this application and not excluded from coverage.
- I will be informed of the status of coverage within 60 days.

I represent 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.

Please Note: Any person who knowingly and with intent to defraud or damage, files a claim containing false, incomplete or misleading information, may be in violation of state law. Use of the mail to defraud is a violation of federal law.

For Florida residents only: 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.

Application Notice (Florida Only)

The certificate you are applying for is primarily governed by the laws of Missouri, the state where the master policy is filed. As a result, all of the rating laws applicable to policies filed in this state do not apply to this coverage, which may result in increases in your premium at renewal that would not be permissible under a Florida-approved certificate. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for any individual health certificate. For information concerning individual health coverage under a Florida-approved certificate, consult your agent or the Florida Department of Financial Services.

Signed at _____ this _____ day of _____, _____
(City/State) (Date) (Month) (Year)

X _____
 Your Signature

X _____
 Your Spouse's Signature, if applying

X _____
 Dependent's Signature, if 18 or older

X _____
 Dependent's Signature, if 18 or older

Applicable to Florida Licensed Agents Only:

X _____
 Dependent's Signature, if 18 or older

Signature of Florida Licensed Agent

Florida Licensed Agent Number

Agent Number

Please Complete for Applicant Demographics

Business Name _____ Business Phone Number _____

Business Address (Street, City, State, ZIP) _____

Type of Business _____ Number of Employees _____

For Agent Use Only

I certify that the answers given to the foregoing questions in this application were provided by the applicant and accurately recorded. I have no information to add to the application that could affect the acceptance or rejection of the risk. I have provided the applicant with the Special Notice Federal Fair Credit Report Act and an outline of coverage where required.

Are you aware of any information, not recorded on the application, which might have a bearing on insurability of any person proposed for insurance? (If Yes, please list details below.)..... Yes No

X _____ X _____
Agent Name Agent Number Agent Signature Date

Agent Phone Number Agent Cell Phone Number Agent Fax Number Agent Email Address

Administrative Details

- 1. Proposal Required. Submit with application – the proposal documents the type of coverage requested.
- 2. Choice of Requested Date of Coverage: Underwriting Approval Date Specified Future Date (1st - 28th) _____
- 3. Health Savings Account Information: Applicant requests HealthEquity open an HSA account according to the terms and conditions of the HealthEquity Service Agreement located at www.healthequity.com
- 4. Payment Mode: **Direct Bill:** Annual Semiannual Quarterly **Monthly:** Bank Draft Credit Card
 List Bill (If requesting a new list bill if allowed in your state, the current list bill forms are required. Submit only application fee, if any, for initial premiums.)
- 5. Payment for Initial Premium: Check Bank Draft Credit Card
\$ _____ Total Amount Submitted With Application (The first full premium by mode, association dues, and the application fee must be submitted with this application.)

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

HIPAA Authorization

I authorize any person described below who has health or non-health information about me or my minor dependents to disclose such information to World Insurance Company and the entities with which it contracts to administer insurance applications (collectively the "Company"), and their agents and representatives. The purpose of the disclosure is so that the information may be used to underwrite and determine eligibility for the insurance plan(s) for which I have applied.

Health information includes information on past and present physical or mental conditions (including, but not limited to, drug and/or alcohol conditions). It includes complete medical files. These files may include, but are not limited to: doctors' notes, lab reports, testing results, consulting doctor reports and test results. The information authorized for disclosure does not include psychotherapy notes.

Non-health information is all other information. It may be about employment, other insurance owned, or motor vehicle, consumer, or credit reports. It may also be information used to confirm questions and answers on the application for insurance.

I authorize disclosure of this information to the Company by any of the following sources: doctors, medical practitioners, hospitals, clinics, or other medical or medically related facilities or professionals; the Company's legal representatives or agents; insurers or reinsurers; health plans; consumer reporting agencies; public records; employers; or the Medical Information Bureau (MIB).

I understand:

- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application(s).
I can revoke this Authorization at any time, except to the extent that the Company has acted in reliance upon it or other law that gives the Company the right to contest a claim under the policy/certificate or the policy/certificate itself.

- Revoking this Authorization means the Company will not be able to consider my application(s). Requests to revoke must be in writing and sent to: World Insurance Company, P.O. Box 3160, Omaha, Nebraska 68103.
Subject to state and federal laws, information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected.
I (or my authorized personal representative) am entitled to and will be sent a copy of this Authorization.
This Authorization expires 24 months from the date I sign it.
I have the right to ask for and obtain a copy of any consumer report made about me to the Company.

I agree that a copy of this Authorization is as valid as the original.

Signature lines for Date, Your Name, Your Spouse's Name, Your Child's Name, and Your Child's Name, with corresponding signature lines and checkboxes.

A personal representative must sign for each minor child. If you are signing as a personal representative for an individual to be insured, read and sign below:

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Person(s) to be Insured (Please Print)

My relationship to applicant(s) (Please Print)

X Personal Representative

Signature lines for Person(s) to be Insured and My relationship to applicant(s).

Authorization to Disclose Information

I authorize World Insurance Company (the Company) to disclose health and non-health information that they may obtain about me to the Medical Information Bureau (MIB). The purpose of the disclosure is fraud prevention. I understand that I do not have to authorize this disclosure to MIB.

Issuance of coverage will not be conditioned on me signing this authorization. Yes No

I understand that, subject to state and Federal laws, information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected.

I understand that I have the right to revoke this authorization at any time except to the extent that the Company has acted upon this authorization. I further understand that if I revoke this authorization I must do so in writing and

must send my written request to: World Insurance Company, P.O. Box 3160, Omaha, Nebraska 68103

I understand that this authorization will expire 24 months from the date I sign it.

I acknowledge that I, or my authorized personal representative, am entitled to and have received a copy of this form.

Signature lines for Date, Your Name, and Your Spouse's Name, with corresponding signature lines and checkboxes.

A personal representative must sign for each minor child. If you are signing as a personal representative for an individual to be insured, read and sign below:

I hereby certify and attest that I am the duly authorized personal representative of these persons to be insured.

Person(s) to be Insured (Please Print)

My relationship to applicant(s) (Please Print)

X Personal Representative

Signature lines for Person(s) to be Insured and My relationship to applicant(s).

