

D. In-Force Medical Coverage

If "yes" for any proposed insured, please complete section below and submit any required replacement forms.

	Yes	No
1. In the 90 days prior to the requested effective date of the policy/certificate, is there any medical coverage (individual or group) in force or pending, including Medicare?	<input type="checkbox"/>	<input type="checkbox"/>

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

2. If "Yes" to number 1, does any proposed insured agree to discontinue any inforce or pending coverage upon the issue of a World policy/certificate?	<input type="checkbox"/>	<input type="checkbox"/>
If "no", explain:		
3. Is replacement or change of existing medical insurance in this company or elsewhere for any proposed insured involved in this application?	<input type="checkbox"/>	<input type="checkbox"/>

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

To be completed if proposed insured is a resident of the State of Florida.

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?	<input type="checkbox"/>	<input type="checkbox"/>
b. Was your most recent period of creditable coverage under a group health plan (employer-sponsored), a governmental plan, or a church plan?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
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?	<input type="checkbox"/>	<input type="checkbox"/>
2. Part A or Part B of Medicare?	<input type="checkbox"/>	<input type="checkbox"/>
3. a State plan under Medicaid, or successor program?	<input type="checkbox"/>	<input type="checkbox"/>
e. Do you have other health insurance?	<input type="checkbox"/>	<input type="checkbox"/>
f. Was your most recent health insurance terminated for nonpayment of premiums, misrepresentation or fraud?	<input type="checkbox"/>	<input type="checkbox"/>
g. Does your current employer or your spouse's employer, offer a group health plan (employer-sponsored)?	<input type="checkbox"/>	<input type="checkbox"/>
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 check i. above, please attach your certification(s) of creditable coverage for the past 18 months to this application.

F. Specifics About Your Health

Note: Any question answered "Yes" in Section E will require complete details in the telephone interview.

- | | Yes | No |
|---|--------------------------|--------------------------|
| 1. In the past 10 years, has anyone been treated for, diagnosed with or had symptoms of any of the following: | | |
| a. Ears/Eyes/Nose/Throat/Lungs or respiratory system | <input type="checkbox"/> | <input type="checkbox"/> |
| b. Heart or circulatory system | <input type="checkbox"/> | <input type="checkbox"/> |
| c. Stomach or digestive system..... | <input type="checkbox"/> | <input type="checkbox"/> |
| d. Kidneys, Urological System or Reproductive system | <input type="checkbox"/> | <input type="checkbox"/> |
| e. Skin, Bones or Muscles | <input type="checkbox"/> | <input type="checkbox"/> |
| f. Nervous system | <input type="checkbox"/> | <input type="checkbox"/> |
| g. Thyroid or Endocrine system | <input type="checkbox"/> | <input type="checkbox"/> |
| h. Cancer or Tumors | <input type="checkbox"/> | <input type="checkbox"/> |
| i. Depression or any Psychological care, Alcohol or Substance Abuse | <input type="checkbox"/> | <input type="checkbox"/> |
| j. Any other conditions..... | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Has anyone taken any prescription or non-prescription medications in the last 2 years? | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please list: _____ | | |
| _____ | | |
| 3. In the past 2 years, has anyone used cigarettes, cigars, pipes, oral tobacco, or nicotine replacements?..... | <input type="checkbox"/> | <input type="checkbox"/> |
| If so, please list: | | |

Name	Date of last use (if quit)
_____	_____
_____	_____
_____	_____
_____	_____

G. Representations

I represent, to the best of my knowledge and belief, that all statements and answers in this application, and in any supplement(s) attached, are true, complete and correct. I understand and acknowledge that:

1. I have received and reviewed the "Completing Your EZ App Personal Profile Interview" handout. I must call World within 3-5 days to complete a Personal Profile Interview (Interview).
2. Any insurance policy/certificate issued relies on my responses in this application and during the recorded Interview. This application and any amendments become part of, and are a basis for, the policy/certificate.
3. I must inform World if any information provided on this application or during the Interview becomes inaccurate or is updated before any policy/certificate is issued.
4. Except as otherwise provided in the Conditional Receipt, no insurance will be in force unless approved by World and accepted by me.
5. Any information that I provide or is gathered through this application process can be shared with persons necessary to facilitate issuing the coverage, including my agent or broker.
6. If any of these conditions are not met, World has the right to rescind its offer of coverage and the full extent of World's liability will be limited to the premium received.
7. The following information is correct and true as it relates to the health insurance being applied for:
 - a. no portion of the premium will be paid by or on behalf of my employer, either directly or through wage adjustments or other means of reimbursement.
 - b. neither I, nor my spouse, nor my dependents, nor my employer intends to treat the policy/certificate as part of a plan or program offered by my employer under Section 162 (other than Section 162(1)), Section 125, or Section 106 of the United States Internal Revenue Code.
8. I authorize payment as noted in Section C of this application.
9. I (or the individual purchasing insurance for child-only coverage) must be an active, dues-paying member of the Association.

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.

Application Notice (Florida Only)

The policy/certificate you are applying for is primarily governed by the laws of Illinois, 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 policy. Any purchase of individual health insurance should be considered carefully, as future medical conditions may make it impossible to qualify for any individual health policy. For information concerning individual health coverage under a Florida-approved policy, consult your agent or the Florida Department of Financial Services.

Application signed at City, State _____

Signature of Member Date Signed

Signature of Spouse (If applying for coverage) Date Signed

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

Signature of Dependent (If 18 or older) Date Signed

Signature of Dependent (If 18 or older) Date Signed

Applicable to Florida Licensed Agents Only:

Signature of Florida Licensed Agent Florida Licensed Agent Number Agent Number

H. 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.

_____	X
<i>Date</i>	<i>Your Signature</i>
_____	X
<i>Your Name (Please Print)</i>	<i>Your Spouse's Signature (if applying)</i>
_____	X
<i>Your Spouse's Name (if applying) (Please Print)</i>	<i>Your Child's Signature (if 18 or older)</i>
_____	X
<i>Your Child's Name (if 18 or older.)</i>	<i>Your Child's Signature (if 18 or older)</i>
_____	X
<i>Your Child's Name (if 18 or older.)</i>	<i>Your Child's Signature (if 18 or older)</i>
<i>Your Child(ren)'s Name(s) if younger than 18 (Please Print)</i>	
1. _____	3. _____
2. _____	4. _____

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 (Please Print)

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.

_____	X
<i>Date</i>	<i>Your Signature</i>
_____	X
<i>Your Name (Please Print)</i>	<i>Your Spouse's Signature (if applying)</i>

<i>Your Spouse's Name (if applying) (Please Print)</i>	

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 (Please Print)

I. Agent Information

Agency Name _____ Agency Number _____
 Agent Name _____ Agent Number _____
 Agent Code _____ Agent Fax Number _____ Agent Phone Number _____
 Agent E-Mail Address* _____
 Agent Signature _____
 Special Instructions: _____

* If you have not registered yet, or if your e-mail address has changed, please visit www.worldsells.com. Communication regarding this application will be through your World Mail Account address.

J. Authorization to Honor Checks Drawn by World Insurance Company

If you select the Bank Draft (EFT) option, please complete the following:

- Initial EFT Only Renewal EFT Only Initial and Renewal EFT

I (we) hereby authorize World Insurance Company (World) to debit entries to the account and depository (Depository) indicated below. This authorization is to remain in full force and effect until World and Depository have received written notification from me (or either of us) of its termination in such time and in such manner to afford World and Depository a reasonable opportunity to act on it. I understand that the withdrawal will be made on the effective date of the policy/certificate (or application date, if applicable).

Signature of Payor _____ Date Signed _____

To begin Bank Draft withdrawals:

Withdrawal date will be effective date of policy/certificate.

Bank Name _____

Address _____

City _____ State _____

To add this policy/certificate to an existing Bank Draft:

Existing EFT Number _____

Policy/Certificate Number _____

Jane Doe 2139 S. 33 St. AnyTown, USA 12345	*(Transit Number) _____	1234
Date _____		
_____ \$		
_____ Dollars		
Bank Name _____		
Memo _____		
(Routing #) _____	(Account #) _____	(Check #) _____

Routing & Transit # (9 digits) _____ Account # _____ Next Check # _____

You must submit a voided check. Do not send a deposit slip. Please print clearly.

TO: The Bank named above

As consideration to you to handle drafts drawn by World Insurance Company on customers of your bank for payment of premiums on insurance certificates, World Insurance Company agrees:

- (1) To indemnify and hold you harmless from any loss you may suffer as a consequence of your actions resulting from or in connection with the execution and issuance of any check, draft or order, whether or not genuine, purporting to be executed and received by you in the regular course of business for the purpose of payment, including any costs or expenses reasonably incurred in connection therewith.
- (2) In the event that any such check, draft or order shall be dishonored whether with or without cause, and whether intentionally or inadvertently, to indemnify you for any loss even though dishonor results in a forfeiture of the insurance.
- (3) To defend at our own cost and expense any action which might be brought by any depositor or any other persons because of your actions taken pursuant to the foregoing requests, or in any manner arising by reason of your participation in the foregoing plan of premium collection.

WORLD INSURANCE COMPANY

Michael E. Abbott

Chairman, President & Chief Executive Officer

Remember to submit the Software Proposal along with all forms!



Application for ACA Membership

I am applying for membership in the Advisory Care Association (ACA). I represent that I am eligible for membership in ACA. My dues will be \$1.50 a month, or \$18 annually. I agree to comply with the By Laws of the association during my membership enrollment and during the term of my membership in the association.

I understand that I will be eligible to apply for health insurance with World Insurance through my membership with ACA. If my application for insurance is approved, I will be issued a policy/certificate of health insurance from World.

I am applying for:

ACA membership and World health insurance

ACA 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 HealthPlan Express insurance agent, who will forward it along with your ExpressMed health insurance application. If you're not applying for health insurance, your agent will forward the membership form and fee alone.

