Preferred Rating Guidelines/Questionnaire

Guidelines – In order to be eligible to apply for *Preferred Rates,* the persons proposed for insurance (Proposed Insured and/or Proposed Insured's Spouse):

a. must be age 18 or older, but not older than age 60;
b. must not have a health exclusion rider or health rate-up added; and
c. must answer **"No"** to questions **1- 6** noted below.

Questionnaire – The following questions must be answered by each person proposed for insurance (Proposed Insured and the Proposed Insured's spouse, if applicable) to determine his or her eligibility for *Preferred Rates.*

	Proposed Insured	**Proposed Insured's Spouse**
1. Have you had a blood pressure reading in excess of 140/90 (more than 140 systolic and/or more than 90 diastolic) or been treated for high blood pressure within the past 12 months?	☐ Yes ☐ No	☐ Yes ☐ No
2. Have you had total cholesterol readings above 220 or been treated for elevated cholesterol or triglycerides within the past 12 months? ..	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you had any convictions for DUI or DWI or have you had more than 2 moving violations within the past 2 years?	☐ Yes ☐ No	☐ Yes ☐ No
4. Have you used tobacco in any form or any nicotine products at any time during the past 2 years?	☐ Yes ☐ No	☐ Yes ☐ No
5. Are you currently outside the weight range shown on the Build Chart for Preferred Risks?	☐ Yes ☐ No	☐ Yes ☐ No
6. Has it been more than 90 days since you had health coverage (group or individual) in force?	☐ Yes ☐ No	☐ Yes ☐ No

Note: Information that we gather during the application process about medical conditions, avocations, or medications you are taking **may** keep you from qualifying for preferred rates.

I understand and agree that this Questionnaire is a part of the application for health/medical insurance coverage with World Insurance Company.

____________________________ ____________________________________
Printed Name of the Proposed Insured | Signature of Proposed Insured | Date

____________________________ ____________________________________
Printed Name of the Spouse | Signature of Spouse | Date

__________________________________ ____________________
Signature of Licensed Agent | Date | Agent Number

Build Chart for Preferred Risks

Male		**Female**	
Height	**Weight**	**Height**	**Weight**
5'0"	98-152	4'10"	90-138
5'1"	101-155	4'11"	92-140
5'2"	103-159	5'0"	94-143
5'3"	105-162	5'1"	96-146
5'4"	107-166	5'2"	98-150
5'5"	110-171	5'3"	101-153
5'6"	112-175	5'4"	104-158
5'7"	115-181	5'5"	107-163
5'8"	118-186	5'6"	109-168
5'9"	121-191	5'7"	112-173
5'10"	124-197	5'8"	115-178
5'11"	126-203	5'9"	117-185
6'0"	129-208	5'10"	119-192
6'1"	132-215	5'11"	122-197
6'2"	135-220	6'0"	123-202
6'3"	139-226	6'1"	126-207
6'4"	143-232	6'2"	130-213
6'5"	146-240	6'3"	134-219

Omaha, Nebraska

Broker

Standard (HIPAA)

Application Packet

States: Illinois, Florida

CB G1052 Pkt

Leave with Client

NCA
Association Membership Application

This insurance plan requires that applicants are members of the association who sponsor this coverage.

Agent Instructions: Please have your customer complete the following application for association membership. If applying for insurance with World Insurance Company, the association membership must be completed, in addition to the insurance application.

- ❑ **Description of Benefits** – *Leave with applicant. These are the benefits available to association members.*
- ❑ **Application for Association Membership** – *Complete the application and submit to World Insurance Company with the insurance application.*

The World For Less

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 more. (NCA members don't have to deal with complicated claim forms, maximums or deductibles.)

  Some of the other benefits NCA members receive include up to 60% savings on monthly dues and month-to-month memberships at more than 1,500 fitness clubs nationwide through the Global Fit Fitness Program; access to online health surveys, reports and tips to assess your health through NHS Info; special pricing for an all-in-one interactive tool kit for a personalized diet and exercise program through Accudiet.com; a handy personal medical profile card you can carry with you through Gateway Medical.

  NCA members can register their children with UBR Child ID Services so authorities can provide faster, more complete assistance if they are missing or abducted. First two children are free; additional children can be added for a fee.

  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 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.

  The association's Travel Assistance program provides numerous benefits if you are traveling more than 100 miles from your permanent resident. (Such as transportation to a medical facility if the local facility cannot provide appropriate treatment, transportation of mortal remains, medical monitoring, legal assistance and vehicle return service.)

  Gulliver's Travel, the official travel agency for the Association Travel Club, offers competitive pricing and great service when purchasing tours and cruises.

- **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.

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. Their Customer Service toll-free number is 800.992.8044.

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

Complete & Submit

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 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 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.

WORLD INSURANCE
Omaha, Nebraska

Complete & Submit

Application for Health Insurance

States: Illinois, Florida

The information in this section will be used to determine the applicant's eligibility for health insurance and to specify which payment method is requested. Application must be submitted on behalf of the customer by the agent.

Agent Instructions: The information in this section will be used to determine the applicant's eligibility for health insurance and to specify which payment method is requested. Applications must be submitted on behalf of the customer by the agent. Please include the following completed forms with the application.

- ❑ **Association Application**
- ❑ **Software Proposal –** Please attach an accurate proposal. This will identify which plan/PPO network/options are being applied for. (If applying for Dental Coverage under Master Policy AM3200, please include on the proposal. Please include correct premium for Dental Coverage.)
- ❑ **Preferred Rating Questionnaire –** M1184, if applicable.
- ❑ **Application for Insurance –** Applicant must answer all questions. Applicant and agent signature is required
- ❑ **HIPAA Compliant Authorization to Obtain Information –** Applicant must read and sign form.
- ❑ **Agent Certification –** Agent completes and signs form.
- ❑ **Authorization to Charge Credit Card OR Automatic Payment Plan –** Applicant completes if electing to pay with credit card or automatic payment plan. Must include a voided check if electing automatic payment plan.
- ❑ **Initial Premium –** Including any fees.
- ❑ **State Mandated Forms –** If applicable.

Utilize the following materials on www.worldsells.com:

- Health Underwriting Guide – W1282

Have any questions about completing the application? Call your General Agent or our toll-free number at 800-733-5454. Product and Marketing questions should be directed to your General Agent or our Marketing Hot Line at 800-995-9010.

Complete & Submit

Application to World Insurance Company
P.O. Box 3160 • Omaha, NE 68103-0160

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 Place to Call	Phone #	Best time to call ☐AM ☐PM
☐ Home (____)	________	________
☐ Work (____)	________	________

4. Spouse's Name *(First, Middle, Last)*

3. a. Member's Employer Address

b. Occupation/Title/Duties

5. a. Spouse's Employer Address

b. Occupation/Title/Duties

6. Persons proposed for insurance. List first, MI, and last names.	Relationship to Insured	Ht. ft., in.	Wt. lbs.	Birthdate Mo./Day/Yr.	Sex	Tobacco Use last 2 yrs. Yes	Tobacco Use last 2 yrs. No	Full-time Student Yes	Full-time Student No	Social Security Number	Driver's License Number/State
						☐	☐	☐	☐		
						☐	☐	☐	☐		
						☐	☐	☐	☐		
						☐	☐	☐	☐		
						☐	☐	☐	☐		

7. a. Parent/Guardian *(if child-only coverage)*	b. Address *(No., Street, City, State and ZIP)*	c. Phone #
8. *a. Payor (if different from above)*	b. Address *(No., Street, City, State and ZIP)*	c. Phone #

9. *Provide details under Additional Remarks in Section F for any questions answered "No".* **Yes No**

a. Is each person to be covered a U.S. citizen?........ ☐ ☐

b. Are all persons to be covered living at the same residence? .... ☐ ☐

c. Do all persons to be covered live or plan to live only in the U.S. or Canada?........ ☐ ☐

B. Type of Coverage Requested

1. **Proposal Required.** Submit with application – the proposal indicates the type of coverage requested.

2. **Please check your choice of Effective Date of Coverage***:* ☐Underwriting Approval Date ☐Specified Future Date ________ *(1st - 28th)*

3. If applying for an HSA plan, and you wish to enroll in a Health Savings Account with HealthEquity, please check here and complete a W1286, and include with the application and proposal.
☐I wish to enroll in a Health Savings Account with HealthEquity

4. **Payment Mode:** ***Direct Bill:*** ☐Annual ☐Semiannual ☐Quarterly ***Monthly:*** ☐Check-O-Matic ☐Credit Card
☐ List Bill *(If requesting a new list bill [if allowed in your state], the current list bill form is required. (Submit only application fee, if any, for initial premiums on list bill. Application Fees are non-refundable unless required by state law.)*
☐ Other ________
Payment for Initial Premium: ☐Check ☐Credit Card *(available only for Monthly Modes)*
*$*__________ 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.

Administrative Use Only

5. ***If "yes" for any member, 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 member 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 member 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? ☐ ☐

Question 6 to be completed if proposed insured is a resident of the State of Florida.

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

C. Health Statement

Yes No

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 Member, 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 ______________

Yes No

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. 1. 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? ☐ ☐

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

2. 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? ☐ ☐

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 <u>*any*</u> 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 ______

Complete & Submit

	Yes	No
g. a mental or nervous disorder, including: ☐ anxiety ☐ A.D.D./A.D.H.D. ☐ eating disorder ☐ learning/behavior disorder ☐ psychiatric treatment or counseling ☐ depression ☐ psychosis ☐ other ____	☐	☐
h. the genitourinary system, including: ☐ prostate ☐ kidney disorder or stones ☐ urinary incontinence ☐ urinary tract infection ☐ bladder ☐ other ____	☐	☐
i. the endocrine system, including: ☐ diabetes ☐ goiter ☐ thyroid gland ☐ high or low blood sugar ☐ glandular disorder ☐ pituitary disorder ☐ other ____	☐	☐
j. the musculoskeletal system, including: ☐ arthritis ☐ gout ☐ TMJ/jaw problems ☐ lupus erythematosus ☐ rheumatism ☐ subluxation ☐ physical handicap ☐ fibromyalgia ☐ loss of limb ☐ knees ☐ the back, spine, or muscles ☐ other ____	☐	☐
k. cancer, tumors, cysts, growths or breast disorders? (Provide location, type and treatment received.)	☐	☐
l. skin disorder/problems, such as psoriasis, keratosis, warts, birthmarks, 2nd or 3rd degree burns, or acne?	☐	☐
m. the eyes, ears, nose, or throat, such as cataracts, glaucoma, speech or hearing impairment, otitis media or ear tubes?	☐	☐
n. any disease or disorder of female/male reproductive systems or genitalia, including: ☐ ovaries ☐ impotency ☐ reproductive organ ☐ irregular menstruation ☐ infertility ☐ uterus/cervix ☐ premenstrual syndrome (PMS) ☐ sexually transmitted disease ☐ other ____	☐	☐
6. ***Questions for female applicants only.***		
a. Any complications of pregnancy, including, but not limited to, caesarean section delivery or miscarriage?	☐	☐
b. Date of last pap smear ____ Results ____ 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?	☐	☐
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. #	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

Ques. #	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

	Yes	No
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)*	☐	☐
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)*	☐	☐

Ques. #	Name of Person	Name of Medication	Dosage & Frequency of Medication	Illness or Condition Treated	Date Last Taken	Name & Address of Physician

F. Additional Remarks

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 association 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 member under the child plan.
      (3) the member is responsible for paying all premiums when due.
   f. 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.
   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 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 files 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 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 ____________________

Applicable to Florida Licensed Agents Only:

____________________ ____________ ____________
Signature of Florida Licensed Agent — Florida Licensed Agent Number — Agent Number

HIPAA Compliant Authorization to Obtain Information

I authorize World Insurance Company and the entities in which it contracts with for administering insurance applications (collectively called the "Company"), its agents and representatives to obtain and use health and non-health information about me and my dependents. This includes information obtained after this Authorization is signed. Subject to state and federal laws, the information can be used to underwrite and determine eligibility for the plan(s) for which I have applied. These plans may include accident and health, Medicare supplement, indemnity, and/or life insurance.

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: physician's notes, lab reports, testing results, consulting physician reports and test results. Such files may also have other information pertinent to health care, advice, or conditions.

This information does not include psychotherapy notes. These notes are separate from the rest of a person's medical record. Psychotherapy notes are defined in 45 C.F.R. 164.501.

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.

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

I also authorize:

- The Company to use any information about me or my dependents it has previously obtained to underwrite any of its plans;
- The Company to use any claims records about me or my dependents from any of its plans. These may be past or currently in force; and
- The MIB to give information to the Company, its legal representatives and/or reinsurers.

I understand:

- The Company may disclose this information:
  1. to reinsurers;
  2. to the MIB;
  3. to other persons or entities that perform insurance-related functions for the Company; and/or
  4. as permitted or required by law.
- I can refuse to sign this Authorization. If I refuse, the Company will not be able to consider my application.
- 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 68103-0160.
- 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 photographic copy of this Authorization is as valid as the original.

After carefully reviewing this authorization, I have decided to voluntarily sign it.

X ______________________________ ______________
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*

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, *(Personal Representative(s) – please print)* ______________________ , hereby certify and attest that I am the duly authorized personal representative of *(Person(s) to be Insured – please print)* ______________, ______________, ______________, ______________. My relationship to the person(s) to be insured is *(Parent, Guardian, Legal Custodian, Power of Attorney, etc.)* ______________. I have the lawful authority to enter into this authorization on behalf of the person(s) to be insured. I have read the provisions in this Authorization. I agree that the Company may use the information obtained about the person(s) to be insured for the purposes set forth herein.

X ______________________________ ______________________________
Signature of Personal Representative(s *Printed Name of Personal Representative(s)*

Agent Certification

Check Box 1 or 2.

☐ 1. I certify that during an in-person interview with the Member, I saw each person proposed for coverage, I have truly and accurately recorded in this application all the information supplied and have witnessed the signatures of the member(s).

☐ 2. If other than #1 above, explain in detail how the completion of the application differed from #1 and the reasons for the differences.

____

____

____

____

	Yes	No
3. Do you have any knowledge or reason to believe that replacement or duplication of existing insurance might be involved?...........	☐	☐
4. Have you reviewed the entire application for corrections or omissions?..	☐	☐
5. Are you aware of any information, not recorded on the application, which might have a bearing on the insurability of any person proposed for insurance. (If yes, please list details below.)..	☐	☐
6. Have you given the member the attached Fair Credit and M.I.B. notices?..	☐	☐

Special requests, remarks and instructions: ______________________________

____

____

____

Agent Name — Please Print ____________ *Agent Code* ____________ *Date* ____________

Agent Phone Number ____________ *Agent Cell Phone Number* ____________ *Agent Fax Number* ____________

Agent e-mail Address ________________________

Register at www.worldsells.com to receive e-mail notification from World.

Agent Signature ________________________

If you are not registered at www.worldsells.com, please do so today.
Registration on World's Virtual Home Office is quick and easy.
You can also log on to update your e-mail address if you are already registered.

Complete & Submit

Authorization to Charge Credit Card for Premium

Available only for monthly modes. Not available in all states.

☐ **VISA** ☐ **MasterCard**

Credit Card Authorization: *I authorize World Insurance Company to bill my VISA/MASTERCARD account for full premium, and any applicable association dues and application fee.* ***NOTE:*** **We will debit your account upon certificate activation which may not coincide with the effective date of the certificate.**

Account Number					—					—					—					Exp. Date			/		

X______________________________ Date ________________
Signature

Phone Number				—				—				

Authorization to Honor Checks Drawn by World Insurance Company

If you select the Check-O-Matic option, please complete the following:
I (we) hereby authorize World Insurance Company (World) to initiate debit entries to the account and depository (Depository) indicated below, to debit the same to such account. This authority 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.

Signature of Payor ____________________________ *Date Signed* ______________

☐ **To begin Check-O-Matic withdrawals:**

Withdrawal date will be effective date of policy/certificate.

Bank Name ____________________

Address ____________________

City ________________ State ______

☐ **To add this policy/certificate to an existing Check-O-Matic:**

Existing COM Number ________________

Policy/Certificate Number ________________

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

Routing & Transit # *(9 digits)* ________________ Account # ______________ Next Check # ________

You must either submit a voided check, or complete the routing and account information. 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

P.O. Box 3160
Omaha, NE 68103-0160

WORLD INSURANCE
Omaha, Nebraska

Leave with Client

Disclosure Forms for Applicant

3

The information in this section must be left with the applicant.

Agent Instructions: The following forms should be left with your customer.

- ❑ **Disclosure –** Agent Signature is required on the Conditional Receipt, if *FULL* premium, and all applicable fees are submitted with application.
- ❑ **Completing Your Personal Profile Interview –** This form describes the process for the telephone interview required for all applicants.
- ❑ **Notice of Privacy Policy and Insurance Information Practices**
- ❑ **Notice of Privacy Practices – Medical**

Leave with Client

WORLD INSURANCE COMPANY • P.O. Box 3160, Omaha, NE 68103-0160

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.

For South Carolina Residents Only: **Disclosure Statement –** You must already be or become a member of the association to be eligible for coverage under the group policy. The member is responsible for all costs related to association membership, including but not limited to the initial association membership fee and the amount of the annual association dues. Membership fees and/or dues are in addition to the policy premium. The association holds the master policy. The premium charged and the terms and conditions of coverage are determined between the association and us. The premium, terms and conditions of coverage may be changed by agreement of the association group policyholder and us, without your consent.

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.

ABREVIATED NOTICE OF INSURANCE INFORMATION PRACTICES

To issue a policycertificate, 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 (where applicable), 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 not be completed.*

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 (where applicable), for this policy/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 policy/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 policy/certificate applied for.
2. This conditional receipt terminates 45 days after the application date, when the policy/certificate applied for is declined or withdrawn, or when the policy/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

X 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. (Central Time).

Make checks payable to World Insurance Company

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

Leave with Client

Completing Your Personal Profile Interview

Thank 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. We will call you as close as possible to the time/day you specified on the application. You will want to set aside approximately 20-30 minutes in a setting where you are able to discuss confidential health information. If it is more convenient for you to call us, you may do so at 800-846-9981, Monday through Friday between 7 a.m. and 9 p.m., Central Time, or Saturday, between 9 a.m. and 3 p.m.

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

Your Partner in Individual Health Insurance Since 1903™

W1209 (7-05)

Leave with Client

11808 Grant Street
Omaha, NE 68164
p.402.496.8300
f.402.496.8040

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.

M1136 (1-05) World GLB Privacy Policy

Leave with Client

11808 Grant Street
Omaha, NE 68164
p.402.496.8300
f.402.496.8040

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.

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 of 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 pur 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.
- 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 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 an/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 your 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.

P.O. Box 3160
Omaha, NE 68103-0160